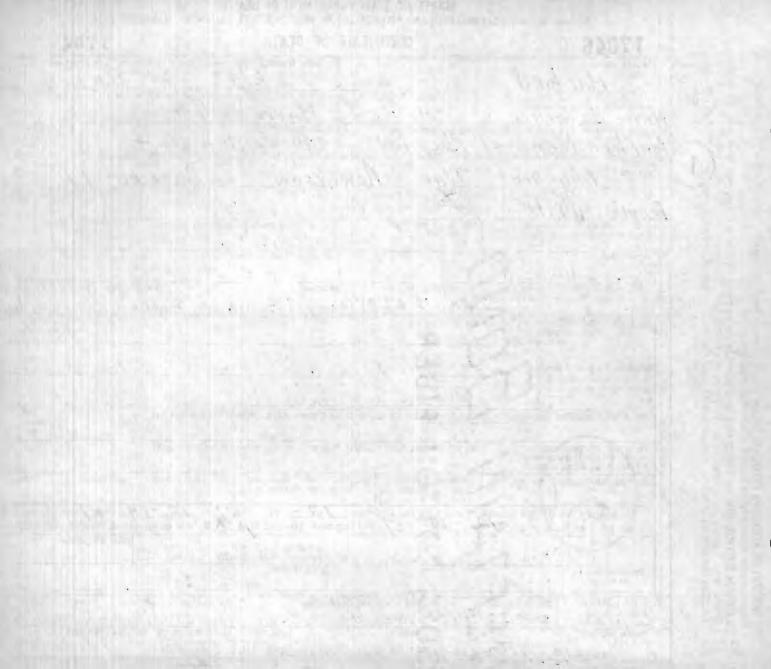
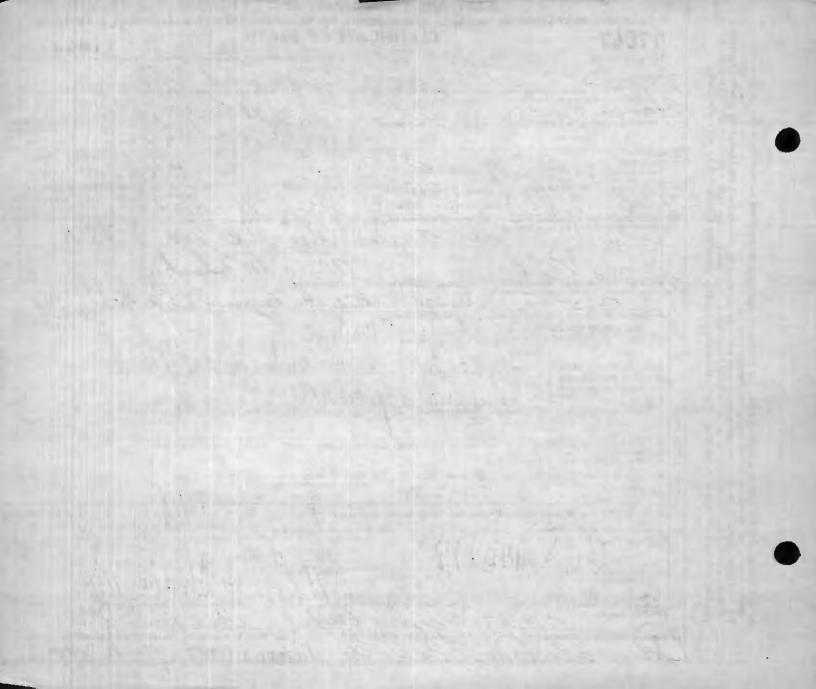
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 17046 17042 death law requires that the death certificate be executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before) admission) ond PLACE OF DEATH the funeral b. COUNTY o. STATE p. COUNTY MARYLAND physicion and completely filled in by the fur C LENGTH OF STAY IN 16 c. CITY OR TOWN (If putside corporate limits, write RURAL and give necrest town) b. Cliy OR TOWN (If autside corporate limits, write RURAL and give pearest town) e. IS RESIDENCE d. STREET ADDRESS d. NAME OF/ROSPITAL OR INSTITUTION (If not in hospital, give street address) ON A FARM? YES NO DY Middle DATE Month Day NAME OF Year OF DECEASED 19 DEATH (Type or print) IF UNDER 24 HRS IF UNDER 9. AGE (In years 6. COLOR OR RACI SEX 7 MARRIED NEVER MARRIED last birthday) Months Hours Dovs DIVORCED WIDOWED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) Ing. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) BALTO, MO 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar removol, WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) CKINSON HAURENE GRAC cremotion. ONSET AND DEATH CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the burial-transit p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** burial, Conditions, if any, which gave rise to immediate couse (a), DUE TO stoting the underlying cause the hospital or attending os the priar to O FUNERAL DIRECTOR: After this certificate hos been last. WAS AUTOPS PERFORMED? PART 11, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CATION for use Health 1 YES NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Not While at work at work be retained by 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive an. 22b. DATE SIGNED 22g. SIGNATURE ATTENDING M.D. DIRECTOR PHYS. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) lirector, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) GRACE HARFORD AVREDE BURIAL 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Cerefan DEC

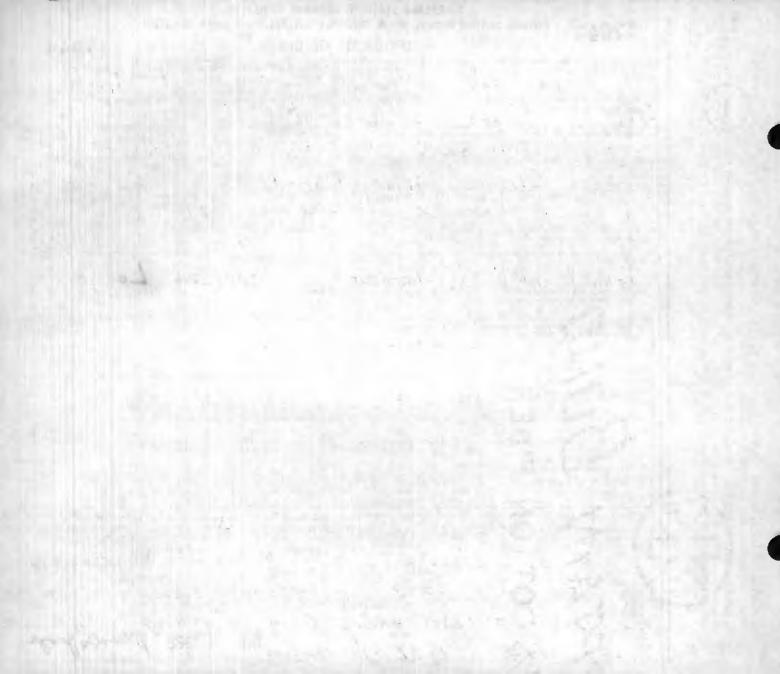
MARYLAND STATE DEPARTMENT OF HEALTH



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH bluods PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, || Institution; Residence before edmission) COUNTY b. COUNTY CITY OR JOWN (if outside comporate limits, C. LINGTH OF STAY IN 16 OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RORAL and give people town) complately filler d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? YES NO paper 3. NAME OF Middle DATE Dev Year DECEASED OF within (Type or print) DEATH 19 carbon 5. SEX 6. COLOR OF RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH IF UNDER 24 HRS. and AGE IN YOUR IF UNDER I YEAR last birthdey) event, Months Hours WIDOWED ICL DIVORCED physician remove 10e. USUAL OCCUPATION (Give kind of work 105-KIND OF BUSINESS OR INDUSTRY W. BIRTHPLACE (County & State, or loreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) une please death .⊆ 13. FATHER'S NAME MOTHER'S MAIDEN NAME attending and ame Then 15/ WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. Address (Yes, no, or unkown) | (Ifyesgivewarordatesofservice) permit. physician 18. CAUSE OF DEATH [Enter only one cause per line for [a], (b), and (c). Š INTERVAL BETWEEN 50 ONSET AND DEATH PART I. DEATH WAS CAUSED BY: signed the burial-transit s burial, cremation, cremation, IMMEDIATE CAUSE (0) DUE TO attending Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying PHYSICIAN: the hospital or cause lost certificate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY 60 (0) 2 CERTIFICATION PERFORMED? use prior NO F After this ce 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Health detached (IF EITHER, NOTIFY MEDICAL EXAMINER) retained by 2Dc. TIME OF INJURY 20d. INJURY OCCURRED I 20e. PLACE OF INJURY (Home, farm, 1 Month, Day, Year 201. (City or town) (County) (State) jo Not While lactory, street, office bldg., etc.] Hour a.m. While DIRECTOR: Dept. at work at work p.m pe 21. I certify that (I) (this hospital attended the deceased from.) (......, 19....., Ihat (I) (we) last 10.10 should State deuses and on the date stated above. M, from the saw the deceased alixed on 1. 19 ...... and that death occurred at ... may 22e. SIGNATURE DATE 3 ATTENDING MED. STAFF SIGNED HOSPITAL FUNERAL DIRECTOR PHYS PHYS. M.D. 22c. PHYSICIAN'S 22d/ ADDRESS NAME (Type) actor, Filed 23e. BURIAL CREMATION, 1 23b. DATE, THEREOF 23c. NAME OF CEMETERY OR GREMATORY ILOCATION (State) の音品 REMOVAL (Specify) 250, REC'D BY REGISTRAR 256, REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE ABORESS Melinelas VR A15



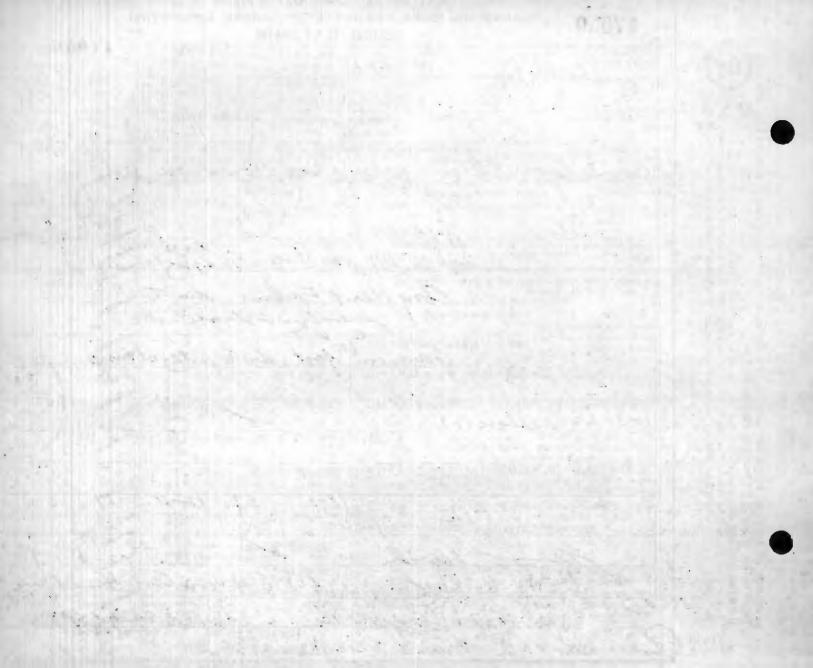
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17048 CERTIFICATE OF DEATH 17044 The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where disceased lived, if institution: Residence before admission) p. COUNTY o. STATE b. COUNTY MARYLAND b. CUY OR TOWN (If outside corporate Amits, C LENGTH OF STAY AN 16 c. CITY OR JOYN (If outside corporate limits, write RURAL and give negrest town) Arite RURAL and give/nearest to d NAME OF HOSPITALOR INSTITUTION e. IS RESIDENCE and completely filled in (If not in hospital, give street, oddress) d. STREET ADDRESS event, within 72 ON A FARM? 66 YES NO [ 3. NAME OF Middle DATE carbon Last Month Year DECEASED (Type or print) DEATH IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED remove birthdoy) Months 2-28.19 Doys Hours ond in any WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work dane 12. CITIZEN OF WHAT 10h. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) **INDUSTRY** COUNTRY by the ottending physician tronsit permit. Then please cremation, or removal, and i 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-tronsit p burial, crematic ONSET AND DEATH IMMEDIATE CAUSE (0) Metastatic Carcinomatose **DUE TO** Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse the hospital or attending as the TO FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) use NO X YES PHYSICIAN: eumonitis for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.) 20o. ACCIDENT WAS UNDERLYING detached f te Dept. af l OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bidg., etc.) Not While ATTENDING ot work at work pe 21. I certify that (I) (this hospital) attended the deceased from be retoined 19 67, and that death accurred at 1 2 DM, from causes and on the date stated above. saw the deceased alive on 12/26 22o. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. × M.D. DIRECTOR PHYS. , poge be filed 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL NAME (Type) 569 Revolution St. Harrede Grace, Md Reorde director, should t 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230. BURIAL CREMATION 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 24. FUNERAL DIRECTOR REC'D BY REGISTRAR DATE JAN VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17049 CERTIFICATE OF DEATH 7045 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Harland Maruland. ecul MARYLAND PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town Perruville papers. Phin 72 hay Havre de Yrace days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) = IS RESIDENCE ON A FARM? d. STREET ADDRESS filled RH 222 within NO X tizens Nursino Home YES carban NAME OF Middle 4. DATE Lost Month Doy Year completely DECEASED OF Vec. trank lounteu Benson. 6 event. (Type or print) DEATH S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years 7. MARRIED NEVER MARRIED DATE OF BIRTH birthdoy) Months Dovs Hours and in any Male alle WIDOWED DIVORCED and 10o, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRYS during most of working life, eyen if refired) physician INDUSTRY Paryland Kexired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remayal, Damonis Barton homas Benson IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service 0 218-18-32824 larence 1. Benson Verruville Md. crematian, 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN the burial-transit ONSET\_AND DEATH IMMEDIATE CAUSE (o) DUE TO signed buriol. Conditions, if ony, which gove (b) rise to immediate couse (o), DUE TO stoting the underlying couse O HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending as the prior to b lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY has PERFORMED? USe Health NO YES certificate for 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I ar Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached 10 (IF EITHER, NOTIFY MEDICAL EXAMINER State Dept. 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour 'a.m. Not While foctory, street, office bldg., etc.) of work of work we 196/ ta Ov. 30, 1967, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. Nov 3 0 19 67, and that death occurred of saw the deceased alive on\_ M, from causes and on the date stated above. FUNERAL DIRECTOR: 220. SIGNATURE. 22b. DATE SIGNED X M.D. DIRECTOR be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Benson Port Deposit Paruland. larence director, shauld 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23b. DATE THEREO 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Hopewell emeteru Port Verosit 24. FUNERAL DIRECTO 750. REC'D BY REGISTRAR 25h. REGISTRAR'S SIGNATUR VR A15 (4) 1961 Patterson & Jon DATE OFC 25M 1/67 l'erruville.

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11	MARYLAND STATE DEPARTMENT OF HEALTH								
	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201								
	CERTIFICATE OF DEATH								
E ( 100 )	1. DECEASED NAME / First / Middle Lost 2a. DATE OF DEATH 2b. HOUL								
ta ( a a a	(Type or print) ( AT Day 16 Year 62 4 4								
	3. SEX 4. RACE S. DATE OF BIRTH 6. AGE (In years I r UNDER 1 YEAR I F UNDER 24 HB								
by the after ages ours after	Female Cancacian 10-6-1883 lost birthday) YRS. MONTHS DAYS HOURS MI								
thaur in by	70. BIRTHPLACE (Stote or foreign of WHAT COUNTRY?  8. MARRIED   NEVER MARRIED   WIDOWED   DIVORCED    9. COUNTY OF DEATH  Or enly								
equires that the death certificate be executed within 24 haurs after death physician. Signed by the attending physician and campletely filled in by the function burial-transit permit. Then please remove carban papers, rages with burial, tremation, or removal, and in any event, within 72 hours after death	10. CITY OR TOWN OF DEATH  11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during most of working life, eyep if retired.)  12b. KIND OF BUSINESS OR during most of working life, eyep if retired.)  11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital OCCUPATION (Kind of work done during most of working life, eyep if retired.)								
be executed wind and campletel in any event, which is the carbon in any event, where it is the carbon in any event.	130. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before) 13c. CITY OR TOWN 13d. IMSIDE CITY UMISS? 13e. STREET AND NUMBER								
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be ex n and se rem d in an	14. FATHER'S NAME First Middle Lost 15. MOTHER'S MAIDEN NAME First Middle Crawfierk								
requires that the death certificate be executed physician. signed by the attending physician and camples burial-transit permit. Then please remove can burial, crematian, or removal, and in any event	160. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, for unknown) (If yes give wor or dates of service) 166. SOCIAL SECURITY NO. 17. INFORMANT Bevan Management (1) Beach Addressure, 101 Beach Be								
g pl	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
ath it in it.	PART I DEATH WAS CAUSED BY: Cong Heart Farlane, due to								
de utter	DUE TO, OR AS A CONSEQUENCE OF CARREST CONTRACTOR OF CONTR								
it the crisit pour pour pour pour pour pour pour pour	Conditions, if ony, which gove								
y #	rise to immediate cause (o),  DUE TO, OR AS A CONSEQUENCE OF								
equires that the physician. signed by the burial-transit burial, cremat	storing the underlying cause DUE 10, OR AS A CONSEQUENCE OF Story Story de transcelle								
hysi gne uria	PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING AND DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
red g p p s i bit	THE E. OTHER SIGNIFICANT CONSTITUTIONS CONTINUED TO BE TO RESTREET TO THE TERMINAL SIGNAL OF CONTINUE OF THE THREE TO								
The law re aftending has been se as the h priar to !	196. DATE OF OPERATION 196. CONDITION FOR WHICH OPERATION WAS PERFORMED 206. AUTOPSY? L206. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING								
ten hen hen hen hen hen hen hen hen hen h	S () 2 / T ( ) CALICES OF DEATHS								
든 6 수 8 수 8	210. ACCIDENT WAS UNDERLYING 21b. TIME OF INURY 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
AN AN ication for Hec									
of all filling	If either, natify medical examiner)   P.M. 19								
OR ATTENDING PHYSICIAN: The be retained by the hospital or all DIRECTOR: After this certificate he ge 3 shauld be detached for use led with the State Dept. of Health	21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street or R.F.D. No. City or Town County State Work all work								
by ti ffer be d	220.   certify that (i) (this haspital) attended the deceased from 1/-1, 1967, ta 12-16, 1967, that (i) (we)								
ATTENDING retained by th rECTOR. After 1 3 shauld be d with the State	sow the deceosed olive on								
A STATE OF S	22b. SIGNATURE 22c. DATE SIGNED 22c. DATE SIGNED								
DIRE DIRE Jed w	The phys. DEGREE PHYS. DIRECTOR PHYS. 1/2-15-6								
O HOSPITAL OF Page 4 may be O FUNERAL DIR director, page 3 should be filled	22d. PHYSICIANS HEARY H. KWAN 22e. ADDRESS 608 5: 11 Mion Cive Hamedlyna								
Userto Ville	230. BURIAL CREMATION, REMOVAL (Specify) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stofe)								
55 6 4 A	REMOVAL (Specify) 12/19/67 Congel Hell Have de Chace, Md								
VR A15	24. FINERAL DIRECTOR 250. REGISTRAR 256. REGISTRAR'S SIGNATURE								
30M REV. 1768	Leseronto My 1 forme de Leve Ma DATDEC 2 6 1967 Actionles Judge								



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1/844 FOR STATE HEALTH DEPT. 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) 1. PLACE OF DEATH p. COUNTY b COUNTY C (ITY OR TOWN (1 outside corporate limits, write RURAL and give nearest lown) MARYLAND b CITY OR TOWN (If outside corporate limits CLENGTH OF STAY IN 16 d NAME OF BOSESAL OR INSTITUTION (If not in hospital, give street oddress) e IS RESIDENCE ON A FARM HILLEN DALE Kd YES NOX NAME OF Lost 4 DATE DECEASED (Type or pont) BLEVINS OF DEATH EC WILLIAM IF JNDER 1 YEAR 9 AGE (In years lost a rthday) yrs 6 COLOR OR RACE 7 MARRIED NEVER MARRIED K Months JUNE 26, WHITE WIDOWED DIVORCED ony event with n 72 hours ofter death OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 1. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT INDUSTRY during most of working life, even if retired) DECATOR NEBRASKA TRUCK 13. FATHER'S NAME FUEL OIL DRIVER 'lilliam '. Tlevins Alta Leona Craig 15 WAS DECEASED EVER NUS ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 215-18-8385 [rs. Ellen Pabina, Box 24, 3.D. 2, eler 11. 18 CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SUFFOCATION AND INTERNAL INJURIES CHEST AND ABDOMEN - , MULTIPLE Conditions, if any, which gove DETO FRACTURES RISS LEFT CHEST, PELVIS rise to immediate couse (b) stoting the underlying couse FEMURS & COMPOUND OF RT. FEMUR 19 WAS AUTOPSY PERFORMED? removal, PART I OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO X 200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of more in Port I or Port II of item 18) cremation, or CRUSHED BETWEEN OIL TRUCK AND TREE IRUNK 20f (City or town) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20c TEME OF INJURY Month, Doy, Year HOME DRIVEWAY BEL AIR 1:25 pm OEC 5 19 67 of work & not While of work may be retained for your FUNERAL DIRECTOR: Poge HARFERD MD 21. I certify that I took charge of the remains described above, held an Autapsy ... Inspection ... Inquiry ... and in my apinion death resulted from Natural causes , Accident , Suicide , Homicide , Undetermined manner CHIEF MEDICAL EXAMINER TO FUNERA.
Heolth prior t ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAM NER SIGNATURE DEPUTY MEDICAL EXAMINER A 307 HICKORY **EXAMINER'S** Address (Street, city town, or county) BEL AIR Ma NAME (Type) 23d LOCATION (City or Town) Bel Air 23c NAME OF CEMETERY OR CREMATORY 230 BUR AL CREMATION. REMOVAL (Specify) Dec. 3.1-67 el Air 'emorial 1976 REED BY REGISTRAR 2Sb REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR VR A15ME (5) Howard K. McComas & Son, Abingdon, Md. 21009 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 7652 CERTIFICATE OF DEATH death. The law requires that the death certificate be executed within 24 haurs after death funeral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND ages c LENGTH DE STAY IN 15 CITY OR TOWN b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) wife RURAL and give pearest town QE. d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) IS RESIDENCE ON A FARM? and completely filled in d. STREET ADDRESS NO S NAME OF First Lost DATE Month Doy DECEASED OF DEATH 070 (Type of print) cember S SEX AGE LF UNDER 1 YEAR 7 MARRIED ( n years NEVER MARRIED lost birthdoy) Months Dovs Hours burial transit permit. Then please remainany WIDOWED DIVORCED 10o JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS DR 11 RIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician a en please COUNTRY? during most of working life, even it retired) Contractor Bullin 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Track WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) HAURE DEGRACE INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital ar attending physician DUE TO Conditions, if ony, which gove rise to immediate couse (a). DHE TO stating the underlying couse be detached for use as the State Dept. af Health prior to certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PARTICIAL ND YES [ 20o ACC DENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour a.m. Not While foctory, street, office bidg, etc.) ot work IO FUNERAL DIRECTOR: After 21 I certify that (!) (this haspital) attended the deceased from Sec 14 196 3 M. from causes and on the date stated above saw the deceased alive on Dec , 20 1967, and that death occurred at 1 220 SIGNATURE L & 22b DATE SIGNED director, page 3 shauld be filed v DIRECTOR M.D 22c PHYSICIAN'S ADDRESS NAME (Type) 23b DATE THEREOF NAME OF CEMETERY OR CREMATORS LOCATION (City or Town) (Stote) 23o BURIAL CREMATION 23c (County) REMOVAL (Specify) VRED 24 FUNERAL DIRECTOR 250 REC'D BY REGISTRAR VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17049 FOR STATE HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o COUNTY b. COUNTY HARFORD Maryland HARFORD MARYLAND C LENGTH OF STAY IN 16 c C TY OR FOWN (If autside carporate limits, write RURAL and give nearest town) b CITY OR TOWN (Il autside carporate limits, write RURAL and give negrest town de Grace P.M3. Departm Aberdeen B IS RESIDENCE ON A FARM? d STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (I not in haspital, give street address) farm Harford Memorial Hospital 103 Edmund Street YES NO XX item 18. Give Pages Office along with far the State after death 3 NAME OF 4 DATE Fist Losi Month DECEASED RAYMOND E. BUDNICK December 20. 19 67 (Type or print) DEATH DATE OF BIRTH 9 AGE (In years S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED lost birthday) Hours 20 April 1905 Male White ofter death WIDOWED DIVORCED within 24 hours 100 USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (State or fareign country) 12 CT ZEN OF WHAT 10b. KIND OF BUSINESS OR during most all working life, even if retired)
Taxi-dab Owner Aberdeen, Maryland pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Frederick H. Budnick Edna L. Walters 17 INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address ward 'pending' the Chief Medical (Yes no, ar unknown) (If yes give war ar dates of service F. Hollis Budnick. Aberdeen, Maryland event with INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) ONSET AND DEATH PART I DEATH WAS CAUSED BY Gunshot wound of head IMMEDIATE CAUSE (a). certificate shauld DUE TO Candilians, if any, which gave nse ta immediate cause (a), DUE TO stoting the underlying couse 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION G VEN IN PART 1(0) YES X NO certificate, 20a EXTERNAL CAUSE WAS PR MARY ☐ or CONTRIBUTING ☐ 20b DESCRIBE HOW IN. JRY OCCURRED (Enter nature all niury in Part ar Part II of item 181) P CAUSE OF DEATH Shot by unknown assailant MEDICAL ( 20e PLACE OF NJURY (Home larm 20d IN.LRY OCCURRED 201 (City or town) (County) (State) 20c TIME OF INCHRY Month, Day, Year factory, street, affice bldg, etc.) Wh e Not While at work of work 9:30 pm 199-20- 1967 street Havre de Grace Harford Md. 21. I certify that I took charge of the remains described above, held on Autopsy [X] Inspect on . Inquiry . ond in my opinion Suicide Undetermined monner death resulted from Notural causes Homic de X funeral directar. Accident CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED 5 may be reto TO FUNERAL DI Health priar to ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY Charles S. Springate, M.D. DEPUTY MEDICA, EXAMINER December 21, 1967 **EXAMINER'S** Address (Street, city, tawn, or county) NAME (Type) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL, CREMATION, (Stote) (County) St Paul Lutheran Cemetery Aberdeen Md. TRINERAL DIRECTOR 250 REC D BY REGISTRAR 25b REGISTRAR S SIGNATURE VR A15ME (\$) Md. 21001



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 17050 requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COLINTY o. STATE ь, соинту MARYLAND b. CITY OR TOWN (if outside corporate limits, r LENGTH OF STAY IN 16 c CITY OR TOWN Alf outside corporate limits, write RURAL and give negrest town OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRÉSS ON A FARM? YES | NO T NAME OF Middle 4. DATE Month Last Year DECEASED OF (Type or print) DEATH AGE (In years IF UNDER I YEAR IF UNDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH 7 MARRIED **NEVER MARRIED** last birthdoy) Months Hours WIDOWED 🖂 DIVORCED 10a, USUA, OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CIT ZEN OF WHAT during most of working lite, even if retired) **GOUNTRY?** INDUSTRY 13. FATHER'S NAME 14. MOTHER'S MÅIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), burial-transit PART I. DEATH WAS CAUSED BY KINAEY IMMEDIATE CAUSE (o) signed by Conditions, if ony, which gove rise to immediate cause (a). DUE TO stating the underlying cause ‡ certificate has been last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED/TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPS PERFORMED? YES N NO ğ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED O FUNERAL DIRECTOR: After this foctory, street, office bldg, etc.) Not While 1967that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased from 1.2 - 2 19 6 7 to saw the deceased alive an and that death accurred at M, fram causes and on the date stated above. 220 SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) 23b DATE THEREOF 23 NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL, CREMATION, (County) (Stote) REMOVAL (Specify) REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4)



	MAKYLAND STATE DEPAKTMENT OF HEALTH
500 67175	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	MEDICAL EXAMINER'S CENTIFICATE OF DEATH
HEALTH DEPT.	1 DECEASED NAME First Middle Lost 20 DATE KNOWN Month Doy Year 2b Hour (Type or Print)
Z 2 2 2	DEATH MATED   Leccassing 720
delay	3 SEX 4 RACE 5 DATE OF BIRTH 6 AGE (In years IF UNDER 14 YEAR IF UNDER 24 NRS. 2c DATE PRONOUNCED DEAD 2d HOUR Months Day's HOURS MAIN Month 7 Day 1 ( Year 7 )
0 8	10 AUG 26, 1910 57 YRS Dec 11 196/3 TH
n, 2	70 BIRTHPLACE (Stote or foreign 70 CITIZEN OF WHAT COUNTRY? 8. MARRIED MEVER MARRIED 70 COUNTY OF DEATH
2 2 2	MI S. T. MOUNTED DIVOKCED 11 6 P) O M
ofter deoth blong with the State, eoth.	10 CITY OR TOWN OF DEATH  11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital   12a. JSJAL OCCUPATION (Kind of work done   12b KIND OF BUSINESS OR   during most of working I fe, even if retired   INDUSTRY//
200	Thus de orke Hastory Menorial House WIFE HOME
hours ofter Item 18. Giv Office along I and 2 with	13a USUAL RESIDENCE (Where deceased lived, if institution Residence before 13c CITY OR FOWN 3d INSIDE CITY DMITS? 13e STREET AND NUMBER
	33 8 A HIN CEY AT LIP SEN - STORY
hours Item 18 Office Jond 2	14 FATHER'S NAME First Middle Last IS MOTHER'S MA DEN NAME First Middle Last
	MICHAEL FODOR ELIZABETH NOGY
hin 24 hours ned in Item 1 niner's Office pages Land 2 hours offer d	160 WAS DECEASED EVER IN U.S. ARMED FORCES? 166 SOCIAL SECURITY NO 17 INFORMANT POLY ADDRESS 3 & SECURITY NO 18 IN
wathin n pencil Examine File pog	- NONE JAMES 1. WITHER STATE ISLAND, 11. Y
	18 CAUSE OF DEATH (Enter only one cause per I ne for (a), (b), and (c) )
be executed "pending" in nief Medicol E snsit permit. F event within	PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (0) PLE INO 2 3 TH EM DO 15 M
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should be e tword "per the Chief uriol-transit in any ever	stating the underlying cause DUE TO, DR AS A CONSEQUENCE OF
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This certificate itiate, writing the be forwarded to do be used as a for removal, and	19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES NO 22 21a EXTERNAL CAUSE WAS 21b TIME OF N. URY Manth, Doy, Year 21c HOW INJURY OCCURRED (Enter nature of njury in Part ) or Part 2, Item 18)
his of the form	AEZ NO SEL
电量 電 9	21d EXTERNAL CAUSE WAS 21b TIME OF N. URY Manth, Doy, Year 21c HOW INJURY OCCURRED (Enter nature of njury in Part 1 or Part 2, Item 18)  PRIMARY [] DR CONTRIBUTING [] HOUR A.M.
e certific e certific should b fites. 3 should	CAUSE OF DEATH P.M 19
	21d IN.URY OCCURRED 21e P.ACE OF IN.URY (At home, farm, street, while Not while Not while Not while Declary, affice building, etc.)
XAM ute the ge 4 your Poge crem	AT WORK AT WORK
ICAL EXAMINER:  execute the cert for. Page 4 shoult ed far your files.  CTOR: Page 3 shoult burial, cremation.	22a. I certify that I taak charge of the remains described above, held an Autopsy 🔲, Inspection 🔀, Inquiry 🔀, and in my opinion
olease e director etained DIRECTOR	death resulted from Natural causes 🔼 , Accident 🗌 , Suicide 🔲 , Hamicide 🔲 , Undetermined manner 🗌
please please retaine retoine or to b	CHIEF MEDICAL EXAMINER
ny, ple eral di be retro RAL D	SIGNATURE ACCION CONTROL ASSISTANT MED CA. EXAM NER 226 DATE SIGNED
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0) = 9	NAME (Type) G-CT d f t 1 mer N ) ADDRESS(Street, city, town, or county) 13 2/ 4 1 1 - 12/
0 = 2 O =	230 BURIAL, (REMATION, 23b DATE 23c NAME OF CEMETERY OR (REMATORY 23d LOCATION (City of Town) (County) (State)
	BURNAL GOECHY DEC. 15, 967 OCEAN VIEW CEM. STATEN, ISLAND N.Y.
VR A15ME (5)	24 FUNERAL DIRECTOR 250 REGISTRARS SIGNATURE 250 REGISTRARS SIGNATURE 250 REGISTRARS SIGNATURE 250 REGISTRARS SIGNATURE
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3.	NAME OF	First	Middle		last 4. I	DATE Moni	h Day	-
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CERTIFICATION	20a. ACCIDENT WA	S UNDERLYING I	Db. DESCRIBE HOW INJURY	OCCUPRED /fata	turn of university But I	Los Part II of them 18. 1	_	
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	21. I certify the	nt (I) (this_bospital)	attended the decease	from July	12 4 196	y to Dee	16.15.1967	that (
	saw the decease	d alive on.	2. (672.19.67)a	nd that death bo	curred at 30 PM	, from the causes	and <b>on</b> the da	te stat
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23	a. (BURIAL) CREMATIO	N. 236. DATE THEREOI	23c, NAME OF C	METERY OR CREMA	TORY 23	d. LOCATION (Gily, Id	wn or county)	-
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24	FUNERAL DIRECTOR'S	SIGNATURE	ADDRESS	1	25e. REC'D 8)	REGISTRAR 256 RE	GISTRAR'S SIGNA	TURF
44	JUNE DIRECTOR :	///	1/ houses	1 24	DEC 2	6 1967 F	harley y	udge

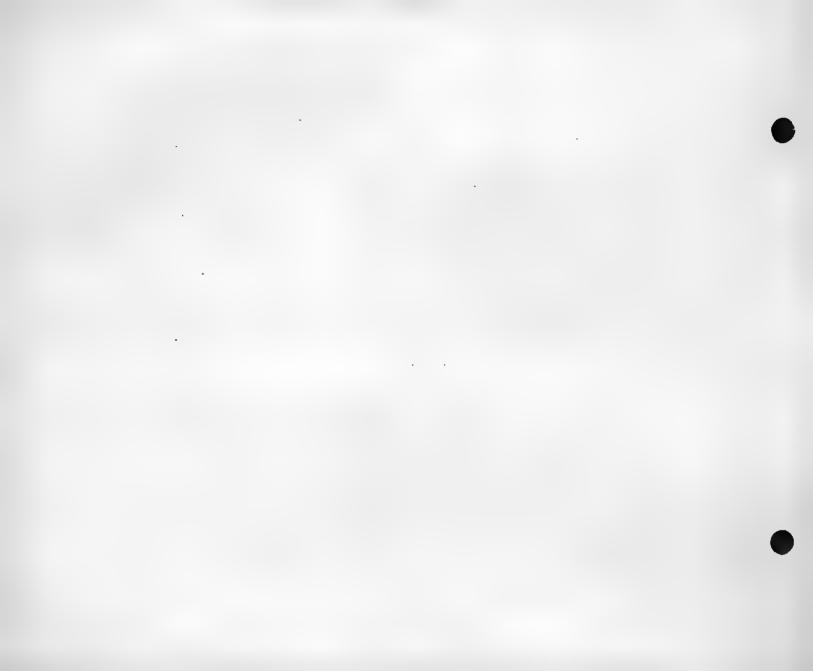


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 17053 PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death 2 USUAL RESIDENCE (Where deceased I ved, if institution. Residence before admission) PLACE OF DEATH b COUNTY Harford a. COUNTY a STATE Maryland Harford MARYLAND b CITY OR TOWN (If autside carparate imits, write RURAL and give nearest tawn) CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate I m ts, write RURAL and give nearest town) Rural - Bel Air 1 week Rural - Bel Air d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? 2006 Valley View Court 2006 Valley View Court NO DE NAME OF Middle 4 DATE Month First lost Day Year DECEASED 19 67 December Gladys Catherine Clark 22. and in any event, (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6 COLOR OR RACE B DATE OF BIRTH 7. MARRIED T NEVER MARRIED past birthday) Days Hours White August 13,1894 Female. WIDOWED DIVORCED and 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) 11 BIRTHPLACE (County & State or foreign country) 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT LOUSTRY? Owls Head, Maine 14 MOTHER'S MAIDEN NAME 13. FATHER S NAME ar removal, Adella Philbrook Frank W. Ames 17 INFORMANT (Hisband) 838-5058 Add 2006 Valley View IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, ar unknawn) (If yes give war or dates af service Bel Air, Md.21014 Mr. Edward Harding Clark 309-10-2597 NTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART : DEATH WAS CAUSED BY IMMEDIATE CAUSE (0) CARDIO - AESP. FAILURGE burial-transit DUE TO HYPERTENSIVE CARDIDURS, DIS. Conditions, if any, which gave rise to immediate cause (o), DUE TO stoting the underlying couse TENSION SOUTHE last WAS AUTOPSY PERFORMED? has PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO X 20g ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or tawn) (Caunty) (State) Hour a.m. Nat While factory, street, affice blda, etc.) ot wark 2]. I certify that (!) (this haspital) attended the deceased fram NONE 1957, to 27052, 1967, that (1) (we) last saw the deceased alive an 210cc 1962, and that death accurred a SFS/ M, fram causes and an the date stated above. FUNERAL DIRECTOR: 22a. SIGNATURE 22b DATE SIGNED ATTENDING STAFF Ded. 22.1967 22d ADDRESS 22¢ PHYS CIAN'S director, po NAME (Type) H. Proctor Sidwell, M.D. 401 Franklin St., Bel Air, Md. 21014 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b. DATE THEREOF (Caunty) BURIAL, CREMATION, Crema tion Baltimore, Maryland Dec.26,1967 Green Mount Crematory 9 . Broadway PRES Williams 2So REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Bel Air, Maryland 21014 Joseph William Foster

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MARYLAND STATE DEPARTMENT OF HEALTH -Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17054 CERTIFICATE OF DEATH dedib requires that the death certificate be executed within 24 hours after death puo USUAL RESIDENCE (Where deceased tived, if institution: Residence before admission signed by the attending physicion ond completely filled in by the funeral buriol-tronsit permit. Then please remove carbon pages. Pages 1 and PLACE OF DEATH o. COUNTY b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 ( CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town) b CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town). 6 IS RESIDENCE ON A FARM? d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (if not in hospito, give street address) a6dod YES NO I NAME OF 4. DATE Dov Year DECEASED
(Type or print) 16 DEATH IF UNDER 24 HRS AGE (In years S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED ugst pirthdoy) Months Hours E8.16, 1388 WIDOWED DIVORCED 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 100 USUAL OCCUPATION (Give kind of work dane 11. BIRTHPLACE (County & State, or fareign country) during most of working life even if retired) COUNTRY INDUSTRY のどりコストーは 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME OFFR 17. INFORMANI Address (If yes give wor or dotes of service ILLIAN C. INJERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one cause per life fof (o), (b) and (c). PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) physician. DUE TO Conditions, if only, which gove rise to immediate couse (a), DUE TO has been s se as the t th prior to b stating the underlying couse Poge 4 may be retoined by the hospital or attending lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO O FUNERAL DIRECTOR: After this certificate ত 20b, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form, (City or town) 20d INJURY OCCURRED (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour om factory, street, office bldg., etc.) 21. I certify that (I) (this haspital) attended the deceased framdirector, page 3 should should be filed with the and that death occurred a warmen M. from causes and on the date stated above saw the deceased alive on 22n SIGNATURE 22b. DATE SIGNED MED. DIRECTOR ATTENDING STAFF PHYS 22c. PHYSICIAN'S 22d. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) 23b. DATE THEREOF (County) BURIAL CREMATION. REMOVAL (Specify) MT. NEBO DEC.15.1967 2So. REC'D BY REGISTRAR ADDRESS 2Sb. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 harle



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 77059 CERTIFICATE OF DEATH 1881 death. The law requires that the deoth certificate be executed within 24 haurs after death filled in by the funeral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. COUNTY o STATE 6 COUNTY haurs offer MARYLAND b CITY OR TOWN (if autside Earparate limits, CLENGTH OF STAY IN 15 c. CITY OR TOWN (If outside carparote write RURAL and give morest towns OF HOSPITAL OR INSTITUTION, (if not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? MORIA YES 🗌 NO X NAME OF Middle DATE Last Month Day Year **DECEASED** AM (Type ar print) .5 DEATH 6 N S. SEX AGE (In years IF UNDER TYEAR IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH ast birthday) Manths Days Haurs WIDOWED DIVORCED rem O O 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or fareign country) 12 CIT ZEN OF WHAT please INDUSTRY COUNTRY? physician 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME cremation, or remayal, the attending parties of the WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war ar dates of service) 18. CAUSE OF DEATH (Enter only one couse per une for (o), (b), and (c), INTERVAL BETWEEN potension of hemorkage ONSET AND DEATH I-transit PART I DEATH WAS CAUSED BY anision signed by t burial-trans burial, crem IMMEDIATE CAUSE (a) 7 **DUE TO** Candeleans, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause attending TO FUNERAL DIRECTOR: After this certificate has been be detached for use as the State Dept. of Health prior to last. WAS AUTOPSY PERFORMED? PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 2 NO by the haspital or PHYSICIAN: 20g. ACC DENT WAS UNDER, YING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 1 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Hour a.m. Nat While factory, street, affice blda., etc.) OR ATTENDING at work L at wark 21. I certify that (1) (this haspital) attended the deceased from be retained director, page 3 shauld shauld be filed with the M, fran causes and an the date stated above and that death accurred at sow the deceased alive on, 22a SIGNATURE 22b. DATE SIGNED DIRECTOR M.D PHYSICIAN S NAME (Type) GOLEIT NAME OF CEMETERY OR CREMATORY 23a. BURIAL CREMATION. 23d LOCATION (City or Town) (State) (County) REMOVAL (Specify) 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67

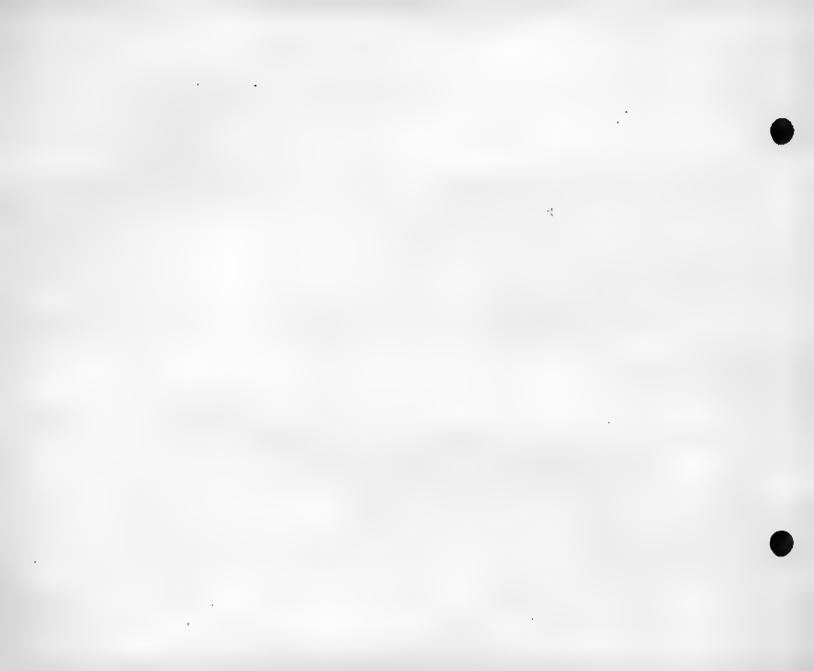


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 havrs after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH campletely-tilled in by the funeral o. COUNTY o. STATE b. COUNTY Harford MARYLAND Harford b. CITY OR TOWN (If outside corporate limits. c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
Havre do Grace 30/to12/6/67 Havre de Grace d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? NO D Citizens Nursing Home 520 S. Stokes St YES 🔲 ug I 3 NAME OF Middle DATE Month Doy Yeor DECEASED FRED DEATH (Type or print) 19 Charles ā IF UNDER 1 YEAR 9. AGE (In years IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIEO 8. DATE OF BIRTH NEVER MARRIED lost birthdov) Months Dovs Hours WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? during most of working life, even if retired) INDUSTRY ABORER H.S. 13 FATHER S NAME 14. MOTHER S MAIOEN NAME 352Address GIRARD, SI WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (If yes give wor or dotes of service) CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit ONSET AND DEATH PART 1. DEATH WAS CAUSED BY. ander Pulmonary IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove (b) Bronched asthon with Bronchiolities and Hon & pecific Ruhmoron Ing rise to immediate couse (a). DUE TO stoting the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been (1) Myocardial Decompensation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPS?
PERFORMEO? far use NO YES 205. DESCRIBE HOW INJURY OCCURRED. (Eyer noture of injury in Part I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING [7] OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Not While 21. I certify that (I) (this hospital) attended the deceased from 12/16 19 60 to 12/6 , 1967, that (1) (we) lost 1967, and that death accurred at 5:50A. M, fram causes and an the date stated above saw the deceased alive on 1215 22b. DATE SIGNED 220 SIGNATURE 2 DIRECTOR M.O. PHYS **PHYS** 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) tansbury, M.D. 569 Revolution Street directar, should 23o. BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) SEMOVAL (Specify) UREDEGRACEMARERO 2So. REC'Q BY REGISTRAR FUNERAL DIRECTOR.

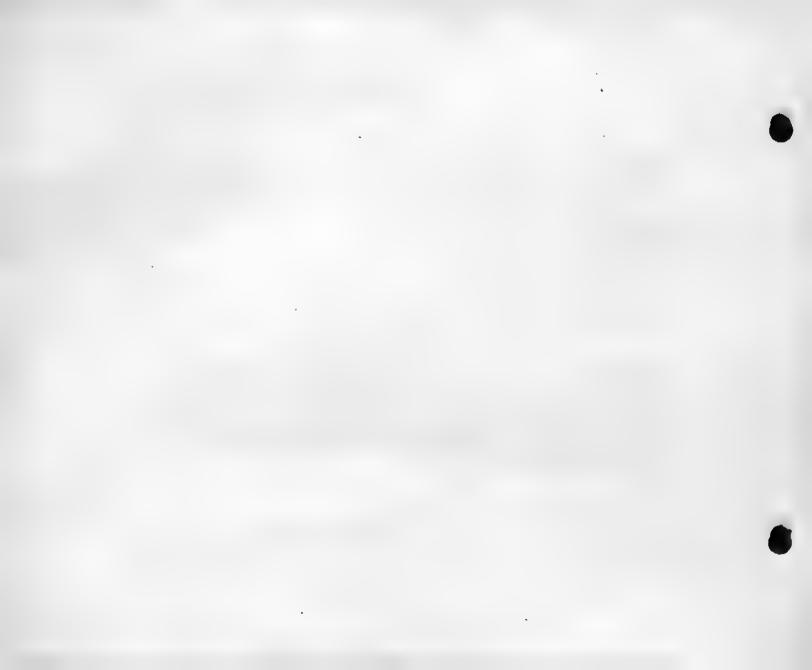


/		- 11 C A Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND	) 21201
. 8 .:		CERTIFICATE OF DEATH	1/056
fureral fureral and 2		PLACE OF DEATH O. COUNTY  MARYLAND  D. CITY OR TOWN (If outside corporate limits, write RURAL or STAY IN 1b)  C. LENGTH OF STAY IN 1b  C. CITY OR TOWN (If outside corporate limits, write RURAL or STAY IN 1b)  C. CITY OR TOWN (If outside corporate limits, write RURAL or STAY IN 1b)	HARFOR D
n haws of	<u>+</u>	b CITY OR TOWN (If outside corporate limits, write RURAL or write RURAL or HOLD COLOR TOWN (If outside corporate limits, write RURAL or HOLD COLOR TOWN (If	e. IS RESIDENCE ON A FARM?
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If the death certificate be executed within 24 the attending physician and completely fillight sit permit. Then please remave carban paparation, ar removal, and in any event, within in the carban paparation, ar removal, and in any event.		NAME OF DECEASED (Type or print) JEMN DIMEO DEATH DECE	Day Year 1967 UNDER 1 YEAR   IF UNDER 24 HRS
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ate be ician ar lease r and in	duri	ing most of working life, even if retired)  WOUSTRY  Listed  Listed	COUNTRY?
certific g phys Then p moval,		Chamen Bureo	
death ittendin ermit. n, ar re	15 (Ye	as, no, or unknown) (If you give wor or dotes of service) Jank Common Dimen all of the	343 A
0		1B. CAUSE OF DEATH (Enter only one couse per line for (a) (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) LE VE C NOTICE TO See	ONSET AND DEATH
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dw randing been been it the iar ta		lost. (c)	
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OR AT be retained as the second as the secon		- ttide (CORRENI) M.D. ATTENDING DIRECTOR DIRECTOR PHYS.	22b. DATE SIGNED (3/17/67
		122c PHYSICIAN'S NAME (Type) £dwjnit @ Loo, M. D 22d. ADDRESS / Covre de Gra	7
ro Hospital Page 4 may ro Funeral director, pag shaul be fi	1	GENERAL (REMATION, DESCRIPTION 12/21/6.7 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of Town)  REMOVAL (Specify) 12/21/6.7 LASSIF HEART	(Caynty) (State)
VR A15 (4) 20 M 1/66	24	4. EUNERAL DIRECTOR ADDRESS 250. REC'D BY REGISTRAR 25b. REGISTRAR 25b. REGISTRAR DATE DEC 26 1987	RAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH



H-	1	1	MARYLAND STATE DEPARTMENT OF HEALTH  Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120	1
		'	17062 CERTIFICATE OF DEATH	054
	requires that the death certificate be executed within 24 hours after death g physician. I signed by the attending physician and campletely filled in by the funeral is burial-tra=sit permit. Then please remave carbay papers, Pages 1 and 2 a burial, crematian, ar remaval, and in any event, within 20 hours after death		PLACE OF DEATH  a. COUNTY  MARYLAND  2. USUAL RESIDENCE (Where deceased lived, if institution: Residence o. STATE  T) d  b. COUNTY  F-7a	before/ydmission)
	by the dgss		b CITY OR TOWN (Il outside carperate limits, c LENGTH OF STAY IN 1b c CITY OR TOWN, (Il outside carperate limits, write RURAL and give no write RURAL	1 1
	filled in	1	HARTORD HEMORIA HOSPITAL OR INSTITUTION (I not in hospital, give, street address) d. STREET ADDRESS  HARTORD HEMORIA HOSPITAL DOY 66 Rt 1	o is residence on a farm? Yes \ no \
:	ptetely f carbay ent, with		NAME OF DECEASED (1/29 or pmrt)  SEX 6 COLOR OR RACE 7, MARRIED 1 8. DATE OF BIRTY  9. AGE (In years IF UNDER 1.9)	Doy Year 19 6 2
	ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed way be retained by the hospital ar attending physician.  RAL DIRECTOR: After this certificate has been signed by the attending physician and camplet, page 3 shauld be detached for use as the burial-tramsit permit. Then please remave car be filled with the State Dept. at Health priar ta burial, crematian, ar remaval, and in any event,		F C WIDOWED 1 DIVORCED 16-28-1895 (ost birthday) Months D	Doys Hours Min.
	ician ar ician ar lease r and in	der		11. SA
4	e death certiticate b attending physician permit. Then please an, ar remaval, and i		WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 224	7
	e death attendir rermit. an, ar re	(Y	es, na, or unknown) (If yes give war or dates of service) 212 - 33 - 48 E3 Mrs. Hannay. Tayior' Port hey	oot, mil
	that the sn. by the ramsit p		18 CAUSE OF DEATH (Enter only one cause per line for (p), (b), ond (c).)  PART I. DEATH WAS CAUSED BY  IMMEDIATE CAUSE (o)  Diabetic  Coloris	INTERVAL BETWEEN ONSET AND DEATH
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	law re ending s been as the riar ta		stating the underlying cause (c) Scabetes Mellitus  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY
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	by the by the fiter this be detailed.	MEDICAL	Hour a.m. p.m.  19 While at work to twork to twork to the deceased fram 12 15, 19 10 10 10 10 10 10 10 10 10 10 10 10 10	that (I) (we) last
	ATTEND stained TOR: A shauld ith the (		saw the deceased alive an 22/18 1967, and that death accurred at 53 M, from causes and an the	date stated above.
	AL OR yy be re L DIRECTOR 3 filled w		220 PHYSICIAN'S DECEMBER J. Standbury M.D. ATTENDING PHYS. DIRECTOR D STAFF DIRECTOR 12/	21/67
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the hospital ar attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 shauld be detached for use as the burial-trans, shauld be filled with the State Dept. af Health priar ta burial, cress.	23		ce, Md.
	P P P S P S P S P S P S P S P S P S P S	2	REMOVAL (Specify) 12-23-67 Berbley Constant Marlington Har A FUNERAL DIRECTOR ADDRESS 2200 REF BY REGISTRAR 7 ASD REGISTRAR'S SIG	HATURE THE
	20 M 1/66/	1	Kener Haellork Newe de Space, Mix DATE 1001	1/ 1



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PT. ∉	DEACE OF DEATH a. COUNTY	(. ۵۶		MARY_A	a. STAT	RESIDENCE (When		f institution; Resident		dmission)
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٠,	d. NAME OF HOSPI	TAL OR INSTITUTION (15 no	ot in hospital give	street address)	d STREET Forge					S RESIDENCE ON A FARM?
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	15. WAS DECEASED EV (Yes, no, or unknown)	ER IN U.S. ARMED FORCES? (If yes give war or dates o	16. SOO 705	ial security no -09-7 <i>5</i> 89	Thomas D	orsey, E	Box 68, 1	Address Abingdon	, Md.	
	PART I DEA	EATH (Enter only one cou TH WAS CAUSED BY IMMEDIATE CAUSE	se per line for (o)	(b), ond (c).)	e)-w+10	e e	VD,s	·ez= -		AL BETWEEN AND DEATH
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	stating the unde	erlying couse	(c)			***************************************				
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	PRIMARY Or CO CAUSE OF DEATH	INTRIBUTING 🗀		IBE HOW INJURY OCCU						
	Hour a.	m. 19	While at work	Not While at work	e PLACE OF INJURY factory, street, of	fice bldg., etc )	20f (City or		(County)	(Stote)
		y that I took chorge ted fram. Nature			Suicide [],	Hamicide	Undeterm			my opinion
	ACTUAL SIGNATURE	Revolut &	Falm	~	M.D. A	HIEF MEDICAL EXAI SS STANT MEDICAL	EXAMINER [ ]	Se/A	7 22.	DATE SIGNED
	EXAMINER'S NAME (Type) 23a BURIAL, CREMATI		Palmer,	23c NAME OF CEMETER	A	EPUTY MEDICAL EX ddress (Street, city			(County)	(State)
	REMOVAL (Specify JUPILA)  24 FUNERAL DIRECTO	d Janes.	1,5,	ADDRESS		1 250 RECTORY	) ame la-	25h REGISTRAR	SIGNATURE	(sidie)
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4	X	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  Them #9 Film #GRETIFICATE OF DEATH	
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OR ATTENIOR DIRECTOR: #		220. SIGNATURE  ATTENDING  ATTENDING  ATTENDING  DIRECTOR  STAFF  129b. DATE SIGNED  12 13-67	
O HOSPITAL OR ATTENDING PH Page 4 may be retained by the h O FUNERAL DIRECTOR: After this director, page 3 shauld be detor should be filed with the State De	1	22d. ADDRESS NAME(Type) Henry H. Kwak, M. D. 22d. ADDRESS NAME(Type) Henry H. Kwak, M. D. 22d. ADDRESS NAME(Type) Henry H. Kwak, M. D. 22d. ADDRESS	<u>e_</u>
TO HOSPITAL Page 4 may TO FUNERAL director, page shauld be file	2:	EMPTH CREMATION (23b. DAY THEREO) 23 MANE OF CREMATORY 23d. MORATION (COUNTY) (State)	
VR A15 (4)		A PUNERI DIRECTOR DE LE REGISTRAR'S SIGNATURE DATE DEC 18 1967 PULLANDES JUNES	



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT	1 PLACE OF DEATH a. COUNTY # 3-+03-  MARYLAND  2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admiss of) b. COUNTY C - C & C
del del	b CITY OR TOWN (If autside carparate imits   C LENCTH OF TAY IN A   C CITY OR TOWN (If autside carparate mits write RURA, and give inearest tawn)   Write RURA and give inearest tawn)
	ON A FARM?  DOA Hartors Menor Follow Sp. To a STREET ADDRESS  ON A FARM?  YES NO ME
hours after death I tem 18. Give Pages Office along with for land 2 with the State	3 NAME OF DECEASED (Type or print) Ly N de 1 ASE Lui N g
urs after n 18. G ce alor d2 with	MIDOWED DIVORCED 9-20-1962 lost birthday) Months Days Hours Mn
24 hours in Hem 1 r's Office ss land 2	10a USUAL OCCUPATION, (Give kind of work done during most of working life even it retired)  10b. KIND OF BUSINESS OR III BIRTHPLACE (State or fareign county)  11 BIRTHPLACE (State or fareign county)  12 CITIZEN OF WHAT COUNTRY?
be executed within 24 pending in pencil in nef Medical Examiner's ansit permit. File pages i ent within 72 haurs offe	William Ewing Agres Rakes
scuted ngʻin dical E armit. F	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, arythorous) (If yes give war or dates at service) NONE WINE WINE WINE COLORA, Md.
s cert ficate shauld be executed within 24 hours after deate, writing the ward "pending" in pencil in Item 18. Give Parfarwarded to the Chief Medical Examiner's Office along with used as a burial-transit permit. File pages land2 with the Stoval, and in any event within 72 hours ofter death	18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Michture 1851 1851 1851 1851 1851 1851 1851 185
shautd ward the C	Conditions, if any, which gave (b)
rert ficate shauld writing the ward rwarded to the Chesed as a burial-tre ral, and in any events.	stating the underlying couse (c)
This cert ficate shauld cate, writing the ward be farwarded to the Chilbe used as a burial-transment of the chilbe used as a factorial of the chilbe used and in any every removal, and in any every	PART I OTHER SIGN F (ANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  19 WAS AUTOPSY PERFORMED?  YES \[ \begin{array}{ c c c c c c c c c c c c c c c c c c c
# <u> </u>	PRIMARY NO CONTRIBUTING   H & H C
EXAMINER: ute the certif age 4 shauld your files Page 3 shauld	20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, factory, street, affice bldg, etc.) 20f (City or town) (County) (State) 436 towns pm 12 6 1967 wark at wark a
MEDICAL EXA please execute director. Page estained far you DIRECTOR: Page r to burial, crem	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my apinion death resulted from: Natural causes, Accident, Suicide, Hamicide, Undetermined manner
UTY MEDIC, ity, please e real directal be retained RAL DIRECT priar to bur	ACTUAL SIGNATURE LEVEL O Palmar ASSISTANT MED CAL EXAMINER BE / A; 7 22. DATE SIGNED
O DEPUTY MEDICAL EXAM necessary, please execute it the funeral director. Page 45 may be retained far your o FUNERAL DIRECTOR: Page Health priar to burial, crema	EXAMINER'S NAME (Type) Condition & Palmen M. D. DEPLTY MEDICAL EXAMINER DAddress (Street, city, rown, or county)
5 Second	BREMOVAL (Spenis) 12-9-67 West No Hinghom CoLord Cec. L Md.
VR A15ME (5)	ADDRESS PADDRESS 250 REC'D BY REGISTRAR 250 REGISTRAR S SIGNATURE OF MELLEN JUNGS



FUNERAL DIREC 3 should page 0

VS A15 (4) 15M 9/58

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registror

1962 That I last saw the deceased 21. I certify that I attended the deceased from alive on ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 22a. BUR AL, CREMATION, 22b. DATE THEREOF 22de LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) Kreol-eems x 24b. REGISTRAR'S SIGNATURE 23/FUNERAL DIRECTOR'S SIGNATURE 24g. REC'D BY REGISTRAR

17061

Days

USA

(County)

e. IS RESIDENCE ON A FARM?

Hours

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES INO [7]

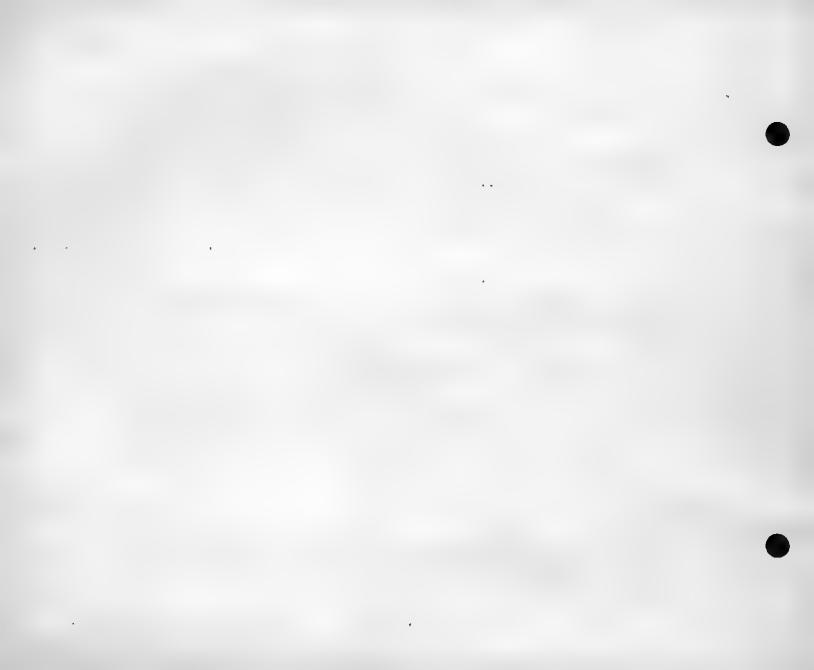
> > (State)

YES NO

Year



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 17062 PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. COUNTY o STATE b. COUNTY Harford Maryland MARYLAND c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest lawn) b CITY OR TOWN (If gutside carparate limits. c LENGTH OF STAY IN 16 write RURAL and give nearest town) Edgwood (tual Edgwood d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? and in any event, within 72 The law requires that the deoth certificate be executed within 24 dod 1802 Old Van Bibber Road 1:02 Old Van Bibber Road YES NO [ NAME OF Middle Last 4. DATE Month Day Year DECEASED Friskev 12 (Type or print) Fred. DEATH S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS last birthday) Manths Davs Haurs Bau WIDOWED 😓 DIVORCED 1-20-1885 106 KIND OF BUSINESS OR 10g USUAL OCCUPATION (Give kind of work done 12 CIT ZEN OF WHAT 11 BIRTHPLACE (County & State, or fareign country) physicion a during most of working life, even if refired) COUNTRY? INDUSTRY U.S.A. Farmer Baltimore Co. Maryl and Metired 13 FATHER 5 NAME 14 MOTHER'S MAIDEN NAME buriol, cremation, or removol, Jnknown George F. Friskey WAS DECEASED EVER IN U.S. ARMED FORCES? 21040 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) Frederick Friskey 1802 Old Van Bibber Road 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: NTERVAL RETWEEN signed by the burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital or attending physician. DUF TO Conditions, if any, which gave 1 rise ta immediate cause (a), DUE TO stating the underlying cause detached for use as the be detached for use as the State Dept of Health prior to PERFORMED? PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) NO V PHYSICIAN: 20a ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I at Part II of item 1B) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm (City or town) (County) (State) MED Nat While factory, street, affice bldg., etc.) at work at work DIRECTOR: After 1965 10 12-29 21. I certify that (1) (this haspital) attended the deceased fram\_\_/ \_ / 1967, and that death accurred of 10 A/M, from causes and on the date stated above. saw the deceased alive on /12 - 1 2200 SIGNATURE 22b DATE SIGNED STAFF DIRECTOR M D PHYS director, page 3 should be filed -22d. ADDRESS FUNERAL NAME (Type) - 2 23d LOCATION (City or Town) 230 BUR-AL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) Md. Carmel emetery Baltimore Co. Buria FUNERAL DIRECTOR 2Sa. REC D BY REGISTRAR 2Sb REGISTRAR S SIGNATURE



1	l	MARYLAND STATE DEPARTMENT OF HEALTH  DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
ala.		A A A A A	ng.,
funeral funeral i and in feath		PLACE OF DEATH o. COUNTY  AMARYLAND  2. USUAL RESIDENCE (Where deceased lived, if institut on Residence o. STATE  Dayland b. COUNTY  Here	before odmission)
hours off Fours of hours of hours of	9	b CITY OR TOWN (If outside Corporate Immis, write RURAL and give in write RURAL on digive necess town)  Live Corporate Immis, write RURAL on digive necess town)  Live Corporate Immis, write RURAL ond give in 12 miles RURAL on digive necess town and give necess town and give necess town are represented by the property of the results of	e IS RESIDENCE
filled in papers	4	Jerford Mem. Hosp. Box 20	ON A FARM?
I withi etely fi arbon it, with	3.	NAME OF DECEASED (Type or print) BABA BOY HARROLD 4. DATE OF DEATH DECEMBER	Day Year 15 19 67
se executed withing and campletely file remaye carbon pin any event, with		SEX, 6 COLOR OR RACE 7. MARRIED 1 NEVER MARRIED 127 8 DATE OF BIRTH 9. AGE (In years 1 FUNDER 1 Y	FAR 16 UNDER 24 HRS. Poys Ours Min
ite be exian and sease remand in an	l'Go dur	b USUAL OCCUPATION (Give kind of work done ring most of wasking life, even if retired)  10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or toteign country) 12. (1717) 13. COUNTRY 13. BIRTHPLACE (County & Stote, or toteign country) 12. (1717) 13. COUNTRY 13. BIRTHPLACE (County & Stote, or toteign country) 14. COUNTRY 15. BIRTHPLACE (County & Stote, or toteign country) 16. COUNTRY 17. COUNTRY 18. BIRTHPLACE (County & Stote, or toteign country) 17. COUNTRY 18. BIRTHPLACE (County & Stote, or toteign country) 18. BIRTHPLACE (County & Stote, or toteign country) 19. COUNTRY	EN OF WHAT
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ne death certificate b attending physician permit. Then please ian, ar remaval, and i	15 (Ye	es, no, or unknown] (If yes give wor or dotes of service) Une Marin King Part Hon 1 Hounds	Jac NO
equires that the physician. signed by the burial-transit burial, cremat		18. CAUSE OF DEATH (Enter only one couse per lingular (o), (b) and (c).)  PART I. DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (o)  DUE TO  Conditions, if any, which gove rise to immediate couse (o), storing the underlying couse (o)  (c)	INTERVAL BETWEEN ONSET AND DEATH
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IG PHYSIC the haspi rr th's certi detached ite Dept. at	MEDICAL	20c. TIME OF INJURY Month, Doy, Year Hour o.m.  Pm. 19  20d INJURY OCCURRED While of work of w	y) (State)
ATTENDING stained by th CTOR: After t should be de		21. I certify that (I) (this haspital) attended the deceased fram 1.5 Acc, 1967, ta 1.5 Dac, 1967, and that death occurred at 1.5 M, from causes and an the	, that (I) (we) las date stated above
O HOSPITAL OR ATTENE Page 4 may be retained O FUNERAL DIRECTOR: A director, page 3 should Should be filed with the		220. SIGNATURE . Name M.D. ATTENDING MED STAFF X 276 DATE	SIGNED
PITAL I may I ERAL D		22c PHYSICIAN S NAME (Type)	
Page 4 may be retained by the FUNERAL DIRECTOR: After the director, page 3 should be detained by the State D	230	SEMOVAL (Specify) 12/16/67. Crugel Hell Harricle The	bunty) (Store)
VR A15 (4)	24	LIVERAL DIRECTOR LAND HOLD SIGNAL DATE DEC 18 1967 Francisco	Eas Juige



PRACE OF DEATH   C. CUNITY		f=1	069	Division of STATI	STICAL RESE	MARYLAND S ARCH AND REG				H ALTIMORE, MARY	LAND 21201	
B. COUNTY Harford  b. (TIVOR TOWN, If carbed corporate lemits, write RURAL and given neonest town)  Harford  b. (TIVOR TOWN, If carbed corporate lemits, write RURAL and given neonest town)  Have de Grace  1. (A NAME OF MOSPIAL OR INSTITUTION) (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give not oddress of street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give not oddress of street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give not oddress of street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give not oddress of street oddress)  NAME OF MOSPIAL OR INSTITUTION (If not in hospital, give n	21	2 <b>4 1</b>	UDT			CERT	IFICATE	OF DEA	TH		3 7	ng.
Harford   Marthano					····			2. USUAL RESI	DENCE (Where d	leceosed lived, if institu	ition. Residence t	aefore odmission)
WITE RUBAL and give nearest town)  Have de Grace  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  J. ANAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  J. ANAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  J. ANAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  J. ANAME OF FIRST  Middle  Lost 4 DATE  OF DEATH  D. COPTIDET  J. DATE OF DEATH  D. COPTIDET  J. DATE OF BIRTH  D. COPTIDET  J. DATE OF BIRTH  J. DATE OF BIRTH  J. DATE (If years in lost birthody)  J. DATE OF BIRTH  J. DATE (If years in lost birthody)  J. DATE OF BIRTH  J. ANAME (If years in returned)  J. ANAME OF BIRTH (If years in returned)  J. ANAME OF BIRTH (If years in returned)  J. ANAME OF BIRTHPLACE (County & Stote, or foreign country)  J. ANAME OF	L		Нал						Md.		Harf	or l
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)   d. STREET ADORESS   e. G. G. T. T. A. D. C. C. S.		write	e RURAL ond	give nearest town)		/					TKMT and diva us	piesi iowi)
S. SEX    6. COLOR OR RACE   FIRST   Middle   Lost   4 DATE   Month   Open	d.	d. NAME	Havro IE OF HOSPITA	de Grace ALOR INSTITUTION (IF	not in hospital,	give street oddress)	12/2//			race	/ *	e. IS RESIDENC ON A FARM
3. NAME OF DECEASED (Type or print)  S. SEX  6. COLOR RACE  7 MARRIED  NUDOWED  NUMOWED  NUM	Gi	.Citi	izen.	Mursing Ho	ome			8/2 0	stego			YES NO
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10. U.S. AL OCCUPATION (G ve kind of work done during most of work done during most of workinglife, even if retired)   10. KINO OF BUSINESS OR PRODUCT   N. R. R.   11. BIRTHPLACE (Country & Stote, or foreign country)   12 citizen of COUNTRY?   13. FATHER'S MADE   14. MOTHER'S MAIDEN NAME   14. MOTHER'S MAIDEN NAME   15. SOCIAL SECURITY NO   17. INFORMANT   18. CAUSE OF DEATH (Enter only one couse per dipe for (c), (b) and To)   18. CAUSE OF DEATH (Enter only one couse per dipe for (c), (b) and To)   19. PART I. DEATH WAS CAUSED BY   16. SOCIAL SECURITY NO   17. INFORMANT   18. CAUSE OF DEATH (Enter only one couse per dipe for (c), (b) and To)   19. VICTORIAN ONSE   18. CAUSE OF DEATH (Enter only one couse per dipe for (c), (b) and To)   19. VICTORIAN ONSE   18. CAUSE OF DEATH (Enter only one couse per dipe for (c), (b) and To)   19. VICTORIAN ONSE   18. CAUSE OF DEATH (Enter only one couse per dipe for (c), (b) and To)   19. VICTORIAN ONSE   18. CAUSE OF DEATH (EALISE (c)   18. CAUSE OF DEATH (EALISE (c)   19. VICTORIAN ONSE   18. CAUSE OF DEATH (EALISE (c)   19. VICTORIAN ONSE   19	3. 367		. 7 .	U. COLOK OK KALL						lost birthdoy)		
13. MAS DECEASED EVER IN U.S. ARMEO FORCES? (Yes, ng, or unknown) (II yes give wor or dotes of service) (Yes, ng, or unknown) (II yes give wor or unknown) (Yes, ng, or unknown) (II yes give wor or unknown) (Yes, ng, or unk	10o U	100 USUAL O	LOCCUPATION	I (G ve kind of work don	e 10b.	KINO OF BUSINESS O	R				12 CITIZE	N OF WHAT
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15. WAS DECEASED EVER IN U.S. ARMEO FORCES?  16. SOCIAL SECURITY NO 17 INFORMANT Address (1/45, ng, or unknown) 18 CAUSE OF DEATH (Enter only one couse per hipe for (a), (b), and (c)) PART 1. DEATH WAS CALSED BY IMMEDIATE CAUSE (a)  18. CAUSE OF DEATH (Enter only one couse per hipe for (a), (b), and (c)) PART 1. DEATH WAS CALSED BY OUE TO Conditions, if only, which gove rise to immediate cause (a), stoling the underlying couse lost.  19. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  200. ACCIOENT WAS UNDERLYING OR OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  200. CONTRIBUTING CAUSE OF OFATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  200. TIME OF INJURY MONth, Doy, Yeor Hour o.m.  21. I certify that (I) (this basinal) attended the deceased from fortony, street, office bidg, etc) Supriature  21. I certify that (I) (this basinal) attended the deceased from fortony, street, office bidg, etc)  220. SIPRIATURE  221. SIPRIATURE  222. SIPRIATURE  224. ADDRESS  NAME (Type)  A. L. Lewis III (L. 214 Union St., Havre de Ynace, III	13. F/	13. FATHER	RS NAME	c. 10	01.				_			
(Yes, no, or unknown) (If yes give wor or dotes of service)   717-07-6070   Ruth V. Johnson, Havne de Ynace, iland   Part I. DRATH (Enter only one couse per the for (c), (b), ond (c)   PART I. DRATH WAS CALSED BY   IMMEDIATE CAUSE (a)   IMMEDIATE CAUSE (b)   IMMEDIATE CAUSE (c)   OUE TO   Conditions, if only, which gove rise to immediate couse (d), stotling the underlying couse lost.   (c)   PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a)   19. VESTIME OF INJURY Month, Doy, Yeor   200 NJURY OCCURRED   Contributing the country of injury in Port I or Port II of item IB.)   200. TIME OF INJURY Month, Doy, Yeor   While   NOT WH	IS. V	IS. WAS DO	DECEASED EVE	R IN U.S. ARMED FORCES	2 16		0 17 1		iruj Dro	//	ress	
18. CAUSE OF DEATH (Enter only one couse pertitipe for (o), (b) and T(c)	(Yes,			(If yes give wor or date:		17_07_607	n Ku	th V. So	ohnson,	Havre de	Уласе, 1	anyland
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206. ACCIOENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF CRATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  206. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19 207. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19 208. PLACE OF INJURY (Home, form, foctory, street, office bidg, etc.) 209. PLACE OF INJURY (Home, form, foctory, street, office bidg, etc.) 201. I certify that (I) (this balance) attended the deceased from  19 201. I certify that (I) (this balance) attended the deceased from  19 202. SIGNATURE  M.D. ATTENDING MED. 212. PHYSICIAN S NAME (Type)  A L Lewis 11. U. 214 Union St., Have de Grace 11.	6	5	II OTHER SH	GNIFICANT CONOITIONS								19. WAS AUTOPSY PERFORMEO? YES NO
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19   20d INJURY OCCURRED While of work   20e, PLACE OF INJURY (Home, form, form, form, form, form, form, saw the deceased five on the deceased from 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five on 19   4 that death occurred of the deceased five of the dec	CERTIF	OR COM	ONTRIBUTING	CAUSE OF CEATH	205. [	DESCRIBE HOW INJUR	Y OCCURRED	(Enter noture of i	injury in Port I c	or Port II of item IB.)		
21. I certify that (I) (this boloinal) attended the deceased from 19 , 19 , to 2 - 3 , 19 , that saw the deceased give on 19 , and that death occurred of 1200 M, from couses and on the date 220. SIDNATURE  220. SIDNATURE  M.D. ATTENDING MED. STAFF 22b. DATE SIGNED PHYS. DIRECTOR PHYS. DIRECTOR PHYS. DIRECTOR PHYS. DIRECTOR PHYS. A Lewis 11.0. 214 Union St., Have de Grace 11.0.	DICAL S	₹ 20c. T								20f. (City or town)	(County	y) (Stot
saw the deceased ative on 19 and that death occurred of Modern courses and on the/dote 220. SIGNATURE  220. SIGNATURE  M.D. ATTENDING MED. STAFF 22b. DATE SIGNET PHYS. DIRECTOR PHYS. DIR	W		p. n	n. 1º	ot wo	ark 🗀 of work 🛭	<u> </u>	1		1.15	106	9 10 1
220. SIGNATURE  M.D. ATTENDING MED. DIRECTOR PHYS. 122b. DATE SIGNET  22c. PHYSICIAN'S NAME (Type)  A. L. Lewis M.U. 214 Union St., Have de Grace, M.		21	<ol> <li>I certificate the distribution</li> </ol>	ty that (I) (this be	ospitary atte	nded the deceos	sed from <u></u>	1			and on the	/that (I) (we dote stoted o
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NAME (Type) A. L. Lewis M. U. 214 Union St., Harre de grace, 11	_		1/8	Salw			M.	D. PHYS.	DIRECT	OR PHYS. [	7/5	27-6
		22c.	NAME (Type)	) /	1. L.	Lennis	M. D.			Нагле а	le Grace	. Ad.
230 BURIAL CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County)	230	230 BURIA	IAL, CREMATIC	DN, 23b. DATE 1	HEREOF	200-20-4	CEMETERY OR					
Burial (Specify) 212-30-67 North (ast Methodist Cem. North (ast Marylano	1	Bun	IOVAL (Specify	1/2-30	0-67		ast me	ethodist				
24 FUNERA DIRECTOR 250. REGISTRAR 256. REGISTRAR'S SIGNATURE DATE JAN 2 1938 REGISTRAR'S SIGNATURE DATE JAN 2 1938	24	24 FUNER	RA DIRECTO	Cotters	www /th	2	11 4			2 1928	REGISTRAR'S SIGN	HATURE BY MANAGE



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17070 CERTIFICATE OF DEATH Z- and afterdeath funeral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) " noond b COUNTY . rollord o. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) 77-17-47-7, -Rocks, Large and Havre de Grace d STREET ADDRESS Rock Ridge Road d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Citicene Turgina Home YES Y NO TO The law requires that the death certificate be executed within 3 NAME OF Middle Lost 4 DATE DECEASED (Type or pnot) Roberta Johnson Jane Dec. DEATH 8. DATE OF BIRTH 1881 S. SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED lost birthdoy) For le WIDOWED Colored DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 1) BIRTHPLACE (County & Stote, or foreign country)
Hariord County 12 CIT ZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Home Louseuri 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Unknown Jude Dorsey IS. WAS DECEASED EVER IN L.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO Address burial-transit permit. (Yes, no, or unknown) (If yes give wor or dates of service) Mrs. Edith cerry Rocks, Lar 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL/BETWEEN PART I DEATH WAS CAUSED BY-IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Conditions, if any, which gove rise to immediate cause (a), DUE TO stoting the underlying couse as the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) for use C.V. A. Coner line 1 A.S.C.V.D., Senility 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18.) 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or fown) 20c, TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (County) (State) Not While foctory, street, office bldg etc.) of work 21. I certify that (I) (this haspital) attended the deceased from 120/10/19 (1)9 6 and that death occurred at 7 30AM, fram causes and on the date stated above saw the deceased alive on 12 22b. DATE SIGNED 22o. SIGNATURE MED. DIRECTOR DELS DM.D. 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) Havre de Gruce. 230. BURIAL (REMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) Chestnut Grove Rocks. Harford, Maryland
25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR 2Sp. REC'D BY REGISTRAR Jarrettsville, Md. DATE A N Charles E. Kurtz



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17866 CERTIFICATE OF DEATH and 2 death. requires that the death certificate be executed within 24 hours after death funerol 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE **b** COUNTY MARYLAND signed by the ottending physicion and completely filled in by the burial-transit permit. Then please remove carbon papers—Rages c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate imits, write RURAL and give negrest town hours e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITA. OR INSTITUTION (If nat in haspital, give street address) NO 020 NAME OF Middle , Lost DATE Manth Year DECEASED OR (Type or print) DEATH CEM 9. AGE (In years IF JNDER DATE OF BIRTH S SEX 6 COLOR OR RACE **NEVER MARRIED** 7 MARRIED Jost birthday) Months Days Hours Min. and in ony WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12. CITIZEN OF WHAT 10a USUA, OCCUPATION (Give kind of work done COUNTRY during most of working life, even if retired) INDUSTRY Penna. House Wile 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO. (Yes no, arunknown) (If yes give war or dates of service) Havre de Grace. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a)
PART I. DEATH WAS CAUSED BY and (c) burial-tronsit ONSET AND DEATH IMMEDIATE CAUSE (a) physicion. DUE TO Conditions, if any, which gave rise ta immediate cause (a). DUE TO stating the underlying cause Poge 4 may be retained by the hospital or ottending O FUNERAL DIRECTOR: After this certificate has been as the l last. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT-NOT, RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION USe Heolth 1 NO 🔽 7-ac jo 205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B.) 20a ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH of detorhed (IF EITHER, NOTIFY MEDICAL EXAMINER (Stote) 20e. PLACE OF INJURY (Home, form, (City or fown) (County) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED factory, street, office,bldg, etc.) Hour o.m. Not-White should be . 1967, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased from \_\_// - . 1967, to 12-13 1967 and that death occurred at 1304M, from causes and on the date stated above saw the deceased alive on. 12 22b. DATE SIGNED 22a, SIGNATURE **ATTENDING** STAFF director, page 3 should be filed v M.D PHYS DIRECTOR PHYS. 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (CityLor Town) (Stote) 23b. DATE THEREOF (County) 230. BURIAL, CREMATION, Pa. Riverview Burial Park (em. Lancaster ADDRESS 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 atterson a Perruville.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 .707 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where degeosed aved, if institution. Residence before agmission PLACE OF DEATH o. COUNTY o. STATE b. COUNTY MARY! AND c LENGTH OF STAY IN 16 c CITY OR TOWN-(If outside corporate limits, write RURAL and give nearest town) by CITY OR TOWN (If outside corporate limits, papers. e IS RESIDENCE ON A FARM? d STREET ADDRESS NAME OF HOSPITAL OR INSTITUTION (If not in hospito, give street, address) within 72 YES NO D NAME OF Middle DATE Month Doy Lost please remove carban signed by the attending physician and campletely burial-transit permit. Then please remove carban DECEASED 19 and in any event, (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years DATE OF BIRTH 6 COLOR OR RACI 7 MARRIED **NEVER MARRIED** iast birthday) Months Hours UC.30, 1933 DIVORCED WIDOWED 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10o USUAL OCCUPAT ON (Give kind of work done 13. BIRTHPLACE (County & State or foreign country) dur ng most of working life, even if retired) COUNTRY 3 **INDUSTRY** ONE 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT permit. unknown) (If yes give wor or dotes of service) MRS, NORMAN crematian, INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) attending physician. DUE TO Conditions, if any, which gove rise to immediate couse (a). **DUE TO** stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been d far use as the af Health priar ta lost. WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING/TD DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 2 CERTIFICATION NO YES be retained by the haspital ar 205. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item IB.) 20o ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH be detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year Hour a.m. factory, street, office bldg., etc.) Not While ot work 21. I certify that (I) (this haspital) oftended the deceased from 1/-30 1967, to 9, 1967, that (1) (we) tost shauld  $\mathbb{Z}_{+}$  and that death occurred at SSPM, from causes and on the dote stated above. saw the deceased alive an 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D. DIRECTOR PHYS PHYS director, page Shauld be filed 22d ~ADDRESS RHYSTCTÁN'S NAME (Type) DATE THEREOF 23d. LOCATION (City or Town) NAME OF CEMETERY OR CREMATORY (County) (Stote) 23a BJRIAL CREMATION. 23€. HAVRE DE GRACE ock ADDRESS 25b. REGISTRAR S SIGNATURE FUNERAL DIRECTOR **VR A15** 



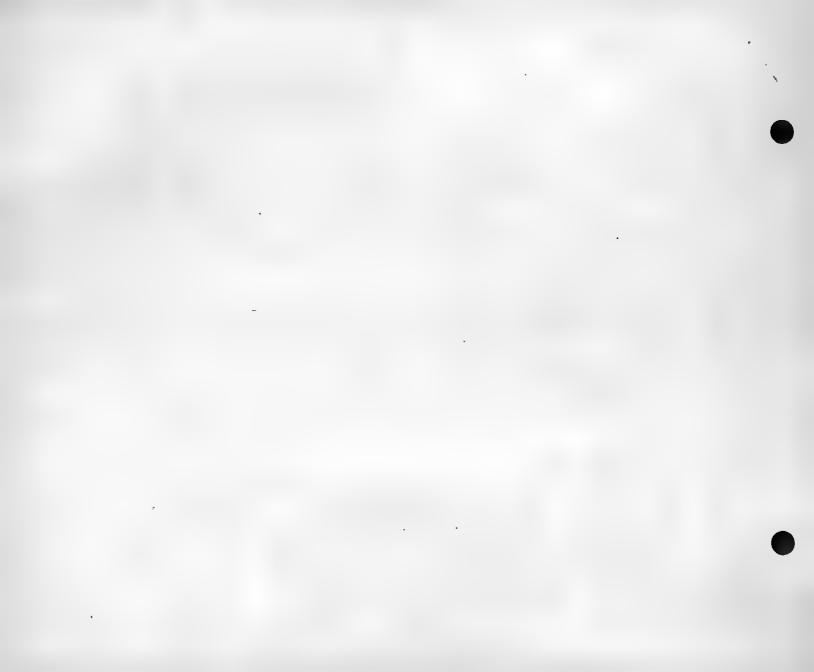
1	7	ウムゥ Division of STATISTIC	MARYLAND STATE DE CAL RESEARCH AND RECORDS, 301			21201
	4	107	CERTIFICATE	OF DEATH	1	7064
1.		DUNTY HARFORD	MARYLAND	2. USUAL RESIDENCE (Where o. STATE MAR	deceosed lived, if institution R	es dence before odmission)  HARford
	W L	TY OR TOWN (If outside corporate limits, trite RURAL and give nearest town)		HAVRE de	orporate limits, write RURAL or	121
1=	He	AME OF HOSPITAL OR INSTITUTION (If not FREE ed Memos	RIAL HOSE.	d. STREET ADDRESS	go, S.T. Month	e. IS RESIDENCE ON A FARM? YES NO C.
3.	DECE	ASED Lester	7. MARRIED THE NEVER MARRIED THE		Decemb	Doy Year  15 19 6 7  UNDER 1 YEAR   IF UNDER 24-9RS.
	11 A	AL OCCUPATION (Give kind of work done	WIDOWED DIVORCED DIVORCED	SEPT. 29 1893 11. BIRTHPLACE (County & Stote	last pirthday) Moi	nths Doys Hours Min,  12. CITIZEN OF WHAT
	5.4	Gottles Hers NAME	PHOUSTRY R. R. R. Hetard	MD-		COUNTRY? A.
1 (		ar gif All E. LIA S DECEASED EVER IN U.S. ARMED FORCES? or unknown) (If yes give war or dotes of s		NFORMANT	NE NAIL Address	
-	18.	CAUSE OF DEATH (Enter only one couse PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o	per line for (o), (b), and (c) )	Occlysion	USAY HAVRE	INTERVAL BETWEEN ONSET AND DEATH
	rise	dutions, if any, which gave to immediate cause (a), ing the underlying cause	Hypothenkin	n - arteris	sacleros	L .
ATION	PAR		ATRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION	N GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO
J CERTIFICATION	20c OR (IF	ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED			
State Dept. of Heolith prior to burial, cremotion, or remayal, and in any event, with the prior to burial, cremotion, or remayal, and in any event, with the prior to burial, cremotion, or remayal, and in any event, with the prior to burial reprintation.	20c	:. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19	While Not While foct	CE OF INJURY (Home, form, ory, street, office bldg , etc.)	20f. (City or town)	(County) (Stote)
	22	21. I certify that (I) (this hasp saw the deceased alive on o. SIGNATURE	ital) attended the deceased fram 1962, and tha	t death accurred at		an the date stated abav
,		C PHYSICIAL'S SELLING	M	D. PHYS DIRECT MED. MED. DIRECT DIRECT MED. DIRECT	STAFF -	17-18-67
2	23o. BL	NAME (Type)  JRIA., CREMATION, 23b. DATE THER	EOF 23c NAME OF CEMETERY OR	CREMATORY 2 2	SI LOCATION (City or Town)	(County) (State)
-	RE	MOVAL Spectivi DEC. 1	8,1967 ST Paul LUTH	PERIAN CEM. A		AR'S SIGNATURE
1/	71.	Madiary Whitakell	NAVREDEGERAC	EMP DATREC 1	9 1967 Roll	mes frege



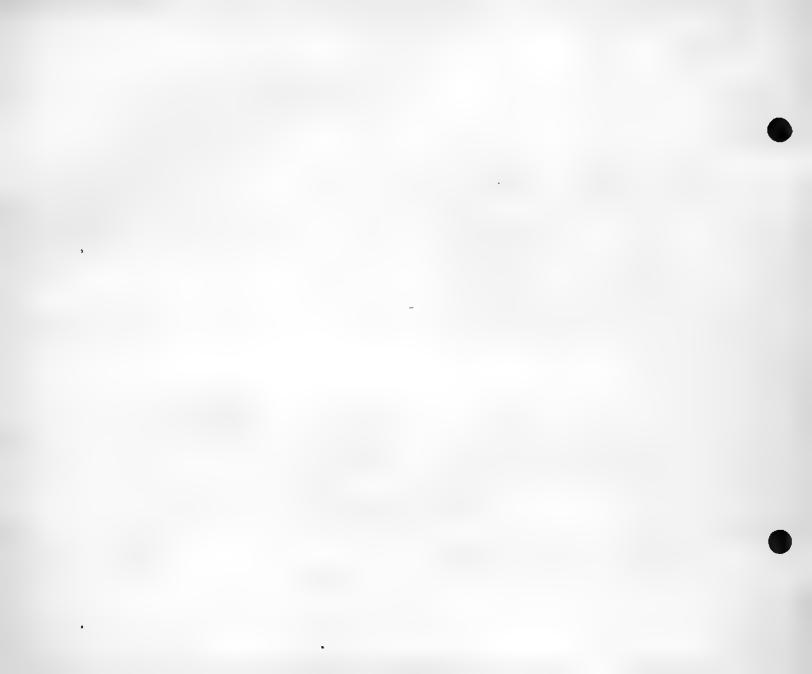
]	Items 20c, f &21 12-18-67 MARYLAND STATE DEPARTMENT OF HEALTH	
	DIVISION OF VITAL RECURDS, 301 W. PRESION SIRREL, DALLMONE, MARILAND 21201	0
FOR STATE	7074 Them #2a Medical examiner's Certificate of Death 170	6 ()
HEALTH DEPT.	PLACE OF DEATH  2 USUAL RESIDENCE (Where deceased lived it institution Residence better to COUNTY 1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	
3 to soge	MARYLAND 1/1/4/ N.J. 14/6/	4-14-11-11
y delay is and 3 to PM3. Page	b (ITY OR TOWN (f autside carparate limits, write RURAL and give neorest town)  C CITY OR TOWN (f autside carparate limits, write RURAL and give neorest town)  C CITY OR TOWN (f autside carparate limits, write RURAL and give neorest town)  C CITY OR TOWN (f autside carparate limits, write RURAL and give neorest town)	
- 14 T	d NAME OF HOSPITA. OR INSTITUTION (finat in haspiral, give street address)  HA7-7-1-V M-M07-1-7/ HUS)>1701  CATHAFLINIST WITH WAS INVESTIGATED  CATHAFLINIST WITH WAS INVESTIGATED.	ON A FARM?  VES NO
24 haurs after death In Item 18. Give Pages r's Office alang with far es land2 with the Mate after death.	3 NAME OF DECEASED (Type or point)  Marth Prist  Middle L. Moor DEATH Prehaber 7	ay Year 7
s after 18. Giv alang with t	S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years FUNDER I YEAR DOTS DOTS DOTS DOTS DOTS DOTS DOTS DOTS	
within 24 haurs of pencil in Item 18 xaminer's Office of pages land 2 whaurs after death.	10a USUA, OCCUPATION (Give kind of work done during group) 12 CITIZEN (COUNTRY) 12 CITIZEN (COUNTRY) 12 CITIZEN (COUNTRY) 13 MINDUSTRY	OF WHAT
in 2 cil in iner's ages s aft	13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME	3 7 7
d within in pencil Examine File page ? haurs c	Henry Long Hester Hightz	
shauld be executed within 24 haurs after de ne ward "pending" in pencil in Item 18. Give F ia the Chief Medical Examiner's Office alang wi burial-transit permit. File pages Tand 2 with the n any event within 72 haurs after death.	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na/or unknawn) (If yes give wor or dates of service)  16 SOCIAL SECURITY NO 17 INFORMANT Ress H Mc Cardell Dein 212 es.	+ N.J.
te execute pending ef Medical nsit permit int within	8 CAUSE OF DEATH (Enter only one couse per ne for (a), (b), and (c))	NTERVAL BETWEEN ONSET AND DEATH
ld be (Chief Chief Chief Ltransite event	PART I DEATH WAS CAUSE (c) TOCTUTE PMU	
shau wa the the any	Conditions, if any, which gave (b)	
This certificate shauld cate, writing the ward be farwarded to the Chilbe used as a burial-tricemaval, and in any every	rise to immediate cause (a), stating the underlying couse DUE TO	
rtifice rating carde d as d as	lost   (c)	9 WAS AUTOPSY
This cert. be farwar	OIL	9 WAS AUTOPSY PERFORMED? YES NO 欠
<u> </u>	200 EXTERNAL CAUSE WAS 200 DESCRIBE HOW INJURY OCCURRED (Enter nature of njury in Part I or Part I of Item 8)  PRIMARY TO OF CONTRIBUTING 1  CAUSE OF DEATH	
<b>至</b> 七 4 元 9 5	20c TIME OF INJURY Month, Day Year 20d NJURY OCCURRED 20e PLACE OF NJURY (Hame farm, 20f (Cty ar fawn) (County)  Hour am 7-1 19 67 While Not While factory, street, aftice bidg, etc.) Rising Sun Ceci	
KEXA xecute Page far yau		nd in my apinian
se exe exter F med for bur of	death resulted fram Natural causes 🔲 , Accident 🔀 , Suicide 🔝 , Hamicide 🔲 , Undetermined manner 🔝	No. 1
MEDICA ease e d rector atained DIRECT	actual Devald ( ) actual Chief Medical examiner ( ) Se / 4 17	22. DATE SIGNED
요_ 끝 . 늘	SIGNATURE MD ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 12-7-	
TO DEPUTY MENTAL E  necessary, p ease exect the funeral d rector Pa 5 may be retained for TO FUNERAL DIRECTOR: PHealth pr ar ta bur al,	NAME (Type) Gerald Man Prans (Street city, town, or county)	0 /
5 = 2 = 2 = 2 = 2 = 2 = 2 = 2 = 2 = 2 =	230 POUR AL, CREMATON, 236 DATE THEREOF 230 NAME OF CEMETERY OR GREMATORY 230 LOCATION (City of Town) (Country of Town) 12-9-67 Chestinul Ridge Cem Falls Ref /32/	4
VR A15ME (5)	24-EUNERAL DIRECTOR  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  DEC I I 1967  REGISTRAR 196250 REGISTRAR 196250 REGISTRAR 196250 REGISTRAR 3 SIGNAL  DEC I I 1967	Judge !
B4 1/1	1141 11KI 1264 V2	



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17075 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death leath. and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o STATE **b** COUNTY MARYLAND 20 c LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town d. STREET ADDRESS IS RESIDENCE d. NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street address) ON A FARM? the attending physician and campletely filled sit permit. Then please remave carbonaryape YES 🗍 NO TX NAME OF Middle DATE Ye01 DECEASED OF (Type or print) DEATH IF UNDER 1 YEAR S SEX 9 AGE (In years IF JNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED birthdoy) Doys Months Hours October 21, 1894 WIDOWED DIVORCED 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County &/Store, or foreign country) 12. CITIZEN OF WHAT during that of working like even if retired) INDUSTRY Home **COUNTRY?** 13 FATHER'S NAME 14. MOTHER 5 MAIDEN 9000 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. BOCIAL SECURITY NO. (Yes, no or unknown) (If yes give war or dotes of service) Perryville. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate couse (o), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been the last. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO XX j 20b, DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [ be retained by the hospital OR CONTRIBUTING CAUSE OF DEATH be detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year Hour om. Not While factory, street, office bldg , etc.) While of work 2). I certify that (I) (this haspital) attended the deceased fram director, page 3 should should be filed with the and that death accurred at 245 M. from causes and on the date stated above. saw the deceased alive an 22b DATE SIGNED 22a, SIGNATURE ATTENDING STAFF PHYS, M.D. DIRECTOR PHYS 22d ADDRESS 22c PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BURIAL, CREMATION DATE THEREOF (County) (Stote) CHEWA FERN Loudon Park Crematory Baltimore. Maryland REGISTRAR, VR A15 ( DATE 20 M 1/66 Tarring Funeral Home Aberdeeń.



p17	MARYLAND STATE DEPARTMENT OF HEALTH
The state of the s	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH
"HEALTH DEPT.	1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed led if institution, Residence before gathission)
is ge ad	O COUNTY HITTORY MARY, AND STATE Maryland COUNTY
D 3 to	b CTTY OR TOWN (to outside corporate limits, C LENGTH OF STAY IN 1b C C TY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
and del	Woodbine  Woodbine
\$ ~ ° ° ( \ \\$ )	d NAME OF HOSPITAL OR INSTITUTION (It not in hospital, give street address) d. STREET ADDRESS, e. IS. RES DENCE
= 2 9 00	OSDOYN & RRCT OSSING Route #2
death with 1	3 NAME OF First Middle oct 14 DATE * Month Day Your
Give Pages and with far	OF DECEMBER OF AND RIVER HOBBS MULLINIX OF DEATH December 25 1967
after along	S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years 15 Under 1 YEAR 15 Under 24 MRS 19st orthogy) Months Days Hours Min
N - 9 - 7 - 5	widowed Divorced 1/4/19 45 yis
Hours Hem Office Office I and 2	100 US_AL OCCUPATION (Give kind of work done done line) KIND OF BUSINESS OR I BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY?
24 In I I I I I I I I I I I I I I I I I I	Far Coention   Larry rd   U.S.A.
within 24 h pencil in It. xaminers 0 Te pages Ic haurs after	13 FATHERS NAME Harrison Kullinix Harrison Kullinix  Harrison Kullinix
l wit Free Free Pree	
7 = 12	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or doles of service) 19-20-1789 In Gene Pullinix, some as #
e execute pending" et Medica sit permit	18 CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c))
eef Antropen	PART 1 DEATH WAS CAUSED BY
shauld be e te word "per to the Chief I burial-transit	MMEDIATE CAUSE (o) O D CN DUE TO
shau the the ony	Conditions, if any, which gove ) (6)
te sl the d ta q by	nse to immediate couse (a).  Stating the underlying couse DUE TO
ficate ting trided rided as a and i	lost (c)
This certificate shauld rate, writing the word be farwarded to the Cl be used as a burial-triemoval, and in any every	PART I OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  19 WAS AUTOPSY PERFORMED?
EXAMINER: This certificate, wright the certificate, wright the farwal your files. Page 3 should be used crematian, ar removal,	PERFORMED?  YES NO PERFORMED.  Y
두그 크리	200 EXTERNAL CAUSE WAS 200 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port Liot item 18.)
EXAMINER: 1 cute the certific age 4 should 1 r yaur files. Page 3 should	
Sharp	20c TIME OF N. LRY Month, Doy, Year 20d IN. LRY OCCURRED 20e PLACE OF INJURY (Home form Hour error 20t (Cry or fown) (County) (State)
XAM tre th yaur yaur remo	pai orwark alwork allowork
EXA  recute Page for you  R. Page  Jr. crem	21 1 certify that I took charge of the remains described above, held an Autapsy 🔲, Inspect an 🔼 Inquiry 🔼, and in my opinion
ortar. Per trans. Per	death resulted fram Natural causes 🔲 , Accident 🔀 , Suicide 🔲 , Hamicide 🔲 , Undetermined manner 🗌
IIY MEDICAL  IIY, pease exe  eral drector. P  be retained fa  RAL DIRECTOR  prior to burial,	ACTUAL SIGNATURE CHIEF MEDICAL EXAMINER ( ) 22. DATE SIGNED
TY DY D	MIGNATURE ACAINATE OF THE MEDICAL EXAMINED TO
Fer Figure 19 Fi	NAME (Type) Gerold C Polars - 10 Address (Street city town, or county)
The Figure 1	230 BURIA, (REMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Co. dry) (State)
The same	REMOVAL(Specify) 12-23-1967 Oak Grove Howard Co., No.
VR AISME	24 FUNERA DIRECTOR  250 RECID BY REGISTRAR 256 REGISTRAR'S SIGNATURE  251 PARTO F.C. 29 1867
6M 1 67 V	0.11.1 1.12, 10x 11, 5; 057110,110.



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1707. FOR STATE PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b COUNTYo. COUNTY MARYLAND c LENGTH OF STAY IN 1b c CITY OR TOWN ( floatside carparate limits, write RURAL and give nearest town) b CITY OR TOWN (It outside corporate im ts and write RURAL and give nearest tawn PM3. Whorthine d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARMS in Item 18. Give Pages 1, Office along with farm Cr 0551 N4 Route Orbornes YES NO [ be executed within 24 haurs after death 3 NAME OF 4 DATE Day DECEASED OF DEATH December (Type or print) S SEX 8 DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost, birthday) Days Manths 9-11-16 W DOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUS NESS OR 11. BIRTHPLACE (State or fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Maryland housewife the Chief Med cal Examiner's home 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME in pencil Alex Powell Sadie 17. INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na\_or unknown) (If yes give war or dates at service) Mr. Gene Vullinix, same as gray avent within INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line far (o), (b), and (c).)
PART I DEATH WAS CAUSED BY ONSET AND DEATH Den Frature Skyll This certificate shauld please execute the certificate, writing the ward DUE TO Conditions, if any, which gave rise ta immediate cause (o). farwarded to DUE TO stating the underlying cause lost. 19 WAS AUTOPS' PERFORMED? PART 1. OTHER SIGN-F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO I 20a. EXTERNAL CAUSE WAS 20h, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port or Part II of item 18.) PRIMARY TO CONTRIBUTING CAUSE OF DEATH shauld cremotian, 20d INJURY OCCURRED (County) 20c TIME OF INJURY Manth Day, Year 20e PLACE OF INJURY (Hame form (( by ar town) Wh. e hat White of wark of war -25 1061 may be retained for your FUNERAL DIRECTOR: Page Aberdeen Ita. 21. I certify that taak charge of the remains described above, held an Autopsy , nspection 🗷 and in my apinian Undetermined manner Accident Suicide death resulted fram. Natural causes Hamicide funeral director prior DEPUTY MEDICAL EXAMINER NAME (Type) (-ex)/d Address (Street city tawn, or county) ealth 23c NAME OF LEMETERY OR TREMATORY 23d LOCATION (Fity or Town) 23b. BURIA! CREMATION 23b DATE THEREOF (County) 0 - RFMGYAL (Specify) 12-20-1967 Grove 24. FUNERAL DIRECTOR ADDRESS 25b. REG STRAR'S SIGNATURE 25a. REC D BY REGISTRAR Box 241, Jykesville, Md. VR ATSME 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, finistrution. Residence before admission o COUNTY o STATE b COUNTY CLENGTH DE STAY IN 16 b CITY DR TDWN (If autside carparate imits, c (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) de write RURAL and give nearest town! d NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS ON A FARM R+ - 40 Office along with far in Item 18. Give Pages pages 1 and 2 with the State YES [ be executed within 24 hours after death 3. NAME OF 4. DATE Month DECEASED OF DEC EMBE 5 SEX 6, COLOR OR RACE AGE (In years 7 MARR ED birthdoy) Months Doys Hours event within 72 haurs after death. WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done BIRTHPLACE (State or foreign country 12 CIT ZEN OF WHA 10b KIND OF BUSINESS OR during most of working le, even if retired) Chief Medical Examiner's pencil 13 FATHERS NAME 14 MOTHER S MA DEN NAME permit. File IS WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown), (If yes give wor or dotes of service) INFORMANT 16 SOCIAL SECURITY NO 18 CAUSE Of DEATH (Enter only one couse per ne for (o), (b), and (c)) burial-transit PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) writing the ward DUE TO and in any Conditions, if only, which gave : (b) rise to immediate couse (o), DUE TO O. stoting the underlying couse farwarded PART II OTHER S GNIFICANT COND T ONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PART TO 9 WAJAUTOPSY PERFORMED? NO D should be 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW N. RY OCCURRED (Enter nature of injury in Port L or Port L of term 18.) 3 shauld PRIMARY CONTRIBUTING C EXAMINER: CAUSE OF DEATH 20c T ME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home form (City or lown) (County) Hour o.m. While Not While of work at work foctory, street, office bldg., etc.) FUNERAL DIRECTOR: Page Inquiry 🔀, Inspection 😿 and in my opinion death resulted from Natural couses Acc dent Suicide . Homic de Undetermined monner the funeral director CH EF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER Health prior pe Address (Street, city town or county) 23b DATE THEREOF OR CREMATORY 0 COMOVAL (Specify) ELNERAL D RECTOR 250 RECU BY REGISTRAR VR A 15ME (5) 6M 1/67



2		Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
	"	CERTIFICATE OF DEATH
funeral funeral fer death		PLACE OF DEATH  O. COUNTY  HARFORL  MARYLAND  2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)  b. COUNTY  HARFORL  MARYLAND
nin 24 haurs after filled ig by the papers. Pages thin (72 hours aft		b CITY DR TDWN (If autside corporate Limits, write RURAL and give nedrest town)  write RURAL and give nedrest town)  A A A A A STREET ADDRESS C-1- Pritchard Ave. e IS RESIDENCE ON A FARM?  A A A A A A A A A A A A A A A A A A A
e executed within ond completely fill remove carbon p in any event, withi	5	NAME OF DECEASED (Type or print) A COLOR OR RACE 7 MARRIED NEVER MARRIED 17 Nov. 1893  NAME OF DEATH DECEMBER 19 4. DATE OF BIRTH DECEMBER 19 4. DATE OF BIRTH DECEMBER 18 19 4. DATE OF BIRTH DECEMBER 18 19 4. DATE OF BIRTH DECEMBER 18 UNDER 24 HRS Min Doys Hours Min Doys Hour
te be extian ond eose remand in ar	100 du	. USUAL OCCUPATION (Give kind of workdone ing most of working ing even (fretired) tor Building Contracting Aberdeen, Maryland U.S.A.
physic physic noval,		FATHER'S NAME  Jacob Osborn  14. MOTHER'S MAIDEN NAME  Ethel M. Jackson
ne death certificate b ottending physician permit. Then please ion, or removal, and i	15 (Y	WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY ND 17 INFORMANT Address 218-10-8365-A Wife, Same as 2 C & D
equires that the physician. signed by the burial-transit burial, cremat	CERTIFICATION	Record   Conditions   Form   Constraint   Constraint   Constraint   Constraint   Conditions   Constraint
NG FEYSI  y the hosp er this cer e detache ate Dept.	MEDICAL	(IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME DF INJURY Manth, Day, Year Hour o.m. p.m.  19   20d. INJURY DCCURRED   20e. PLACE DF INJURY (Home, farm foctory, street, affice bldg., etc.)   20f (City or town)   (County)   (Stote)   20e. PLACE DF INJURY (Home, farm foctory, street, affice bldg., etc.)   20f (City or town)   (County)   20f (City or town)   20f (Cit
Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to		21. I certify that (I) (this haspital) attended the deceased fram
Page 4 Corner of Page 4 Definence of Page 4	23	o Burial, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) BUTTLE Pecify) 21 Deg. 1967 Bakers Cemetery Aberdeen, (Harford) Maryland
VR A15 V4		4. FUNERAL DIRECTOR ADDRESS 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATTIFIC TUDE TUDE TO THE ADDRESS DATTIFIC 2 1 1967 Plantage and Address DATTIFIC 2 1 1967 Plantage Address DATT

1 1		DEPARTMENT OF HEALTH PRESTON STREET, BALTIMORE, MARYLAND 2	1201
	\$ 23 1 A	CATE OF DEATH	2075
or death.	1. PLACE OF DEATH O COUNTY HAR FOR D MARYL		institution Residence, before admission) b COUNTY  HALLO I
haurs after the rs. Page Traury after	b. CITY OR TOWN (if autside carparate limits, c. LENGTH OF STAY IN write RURAL god give nearest tawn)  AND EDE GODAL CO.  d., NAME OF POSPITAL OR INSTITUTION (If not in haspital, give street address)	1b c. CITY OR TOWN of outside carparate limits, w  S	O (: 15 RESIDENCE
in 24 hilled	HArtord L'emorial Hosp	1. 212.5. Kogers (	ON A FARM?  VES NO TO
completely filled ove carbon prop y event, within	3 NAME OF DECEASED (Type or print) LENG First VICQINIA T	ACALIA DEATH DEC	ember 20 1967
a comp move c	5 SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED DIVORCED	B DATE OF BIRTH  June 20, 1916  9 AGE (in y lost birth 51	oday) Months Days Hours Min.
e death certificate be ex attending physician ond permit. Then please rem on, or remaval, ond in an	100 USUAL OCCUPATION (Give kind of work done during most of working life even if retired)  Restaurant owner Restaurant	11 BIRTHPLACE (County & State, or largery country flouth of Wilson, Virg	COUNTRY
tifica on playsis	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	/n\
ng p The	Fred Vanight  15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.	Ida Rutherford	(D)
he death attendir permit. ion, or re	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) NO	Husband-Same as 2 C &	& D
nat the ( ). y the att insit per	18. CAUSE OF DEATH (Enter only one cause ptr , ne for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	arcinometress Abdem	NTERVAL BETWEEN ONSE AND GENTH
PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death the hospital or attending physician. The certificate has been signed by the attending physician and completely filled in the fundamental permit. Then please remove carbon places. Page 1.5 Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 haurs after death.	Conditions, if any, which gave inse to immediate cause (a), stating the underlying cause last.	chems of overly	4 mo.
IAN: The law retal or	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA	TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	1(a) 19 WAS AUTOPSY PERFORMED? YES NO
he hospirol or this certificate estached for us Dept. of Health	200 ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  200. TIME OF INJURY Month, Day, Year Hour a.m.  Not While Not While	URRED (Enter nature of injury in Part or Part It of item	78)
IG PHYSIC the hospi or this certi defached ate Dept. o	20c. TIME OF INJURY Month, Day, Yeor 20d INJURY OCCURRED Hour o.m. 19 while at work at work 19 at work 19	20e PLACE OF INJURY (Hame, farm factory, street, office bldg , etc.)	awn) (Caunty) (State)
TAL OR ATTENDING PHYSing be retained by the hosp AL DIRECTOR: After this cepage 3 should be detached filed with the State Dept.		d that death accurred at 3 M, fram to	auses and an the date stated abave
HOSPITAL OR ATTEN age 4 moy be retained FUNERAL DIRECTOR: A irector, page 3 should hould be filed with the	220. SIGNATONIA	M.D ATTENDING MED DIRECTOR PHYS	22b. DATE SIGNED 12 - 67
SPITAL 4 moy IERAL 4 or, pag d be fil	221 PHYS CIAN'S PETER P. KOO WEN [N]	) 220 ADDRESS ST. POEVER	
ro Hospital Page 4 moy For Funeral director, page	230 BURIAL (REMATION, 23b DATE THEREOF 23c NAME OF CEMET BURIAL PROPERTY) 23 Deg. 1967 Baker Ce	meteby Aberdeen	(Harford) Martland
VR A15 (4)	28 TUNERAL DIRECTOR ADDRESS	250 REC D BY REGISTRAR 1967	25b REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 . 7081 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY o. STATE Maryland b. COUNTY Harford Harford MARYLAND b CITY OR TOWN (If outside corporate limits, we te RURAL and give nearest town)

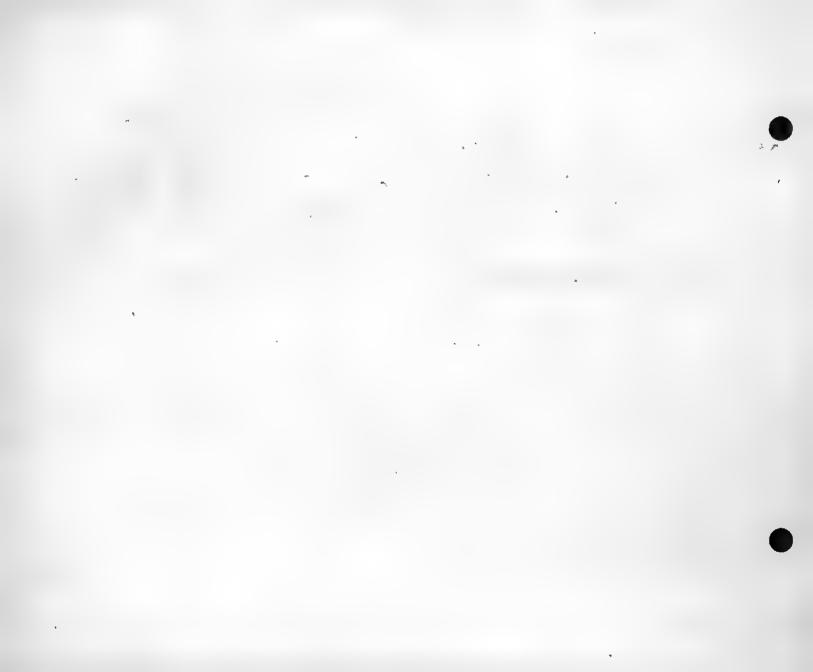
Havre de Grace C LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate imits, write RURAL and give nearest town) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs aft 36 days Rural - Bel Air d NAME OF HOSP TAL OR INSTITUT ON (If not in hospital, give street address) = d. STREET ADDRESS ON A FARM? Conowingo Road Harford Memorial Hospital YES NO P NAME OF Middle 4. OATE carban Doy Year DECEASED 67 Poplin December 18. Boulah Jane DEATH and in any event, IF LINDER I YEAR S. SEX AGE ( n years 6. COLOR OR RACE DATE OF BIRTH 7 MARRIED NEVER MARRIED March 29,1904 birthday Haurs White Female WIDOWED DIVORCED | pug TDo LSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
Housewile attenting physician operate Homema ker Sparta, North Carolina 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, Robert L. Choate Vene Jane Taylor 17 INFORMANT (Husband) 838-6664 Address P.O. Box#244 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no, ar unknown) (If yes give war ar dates af service) Mr. J. Quincy Poplin Bel Air. Md. 21014 219\_16\_3637 burial, crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY-4 WEEKS burial-transit IMMEDIATE CAUSE (0) Congestive heart failure terminating signed Conditions, if any, which gave Chronic A.S.C. V D rise to immediate cause (a), DUE TO stating the underlying cause this certificate has been detached for use as the te Dept. of Health prior to PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE FERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? Multiple sclerosis 1941: Radical mastectomy ca 2Da ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of mury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Hame, farm, (City or fawn) (State) 20c. TIME OF INJURY Month, Day, Year (County) factory, street, office blda., etc.) Hour om. Not While 1941 , ta Dec 18, 19, 67 that (I) (WDSast 21 I certify that (I) (this haspital) attended the deceased fram. 19 be retained , and that death accurred at 6:2 M, fram causes and on the date stated above. saw the deceased alive anDec. TO FUNERAL DIRECTOR: 22a. SIGNATURE Dec.18,1967 MED. DIRECTOR O.M 22d ADDRESS 22c PHYSICIAN'S Forest Hill, Maryland director, po shauld be f Willard P. Hudson, M.D. NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BUR AL CREMATION. 23b DATE THEREOF (Co21014 (State Bel Air Memorial Gardens | Bel Air, Harford Co., Md. Dec.20.1967 Broadway DE Williams St. 2Sa REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR **V■** A15 Bel Air, Maryland 21014 DATE DEC 20 25M 1/67 Joseph William Foster

~ ( - [

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 707. deoth. the law requires that the death certificate be executed within 24 haurs after death puo USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) PLACE OF DEATH a. COUNTY o. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town CITY OR TOWN (If autside corparate write RURAL and give negrest town e IS RESIDENCE NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET\_ADDRESS filled NO burial, cremation, or removal, and in any event, within NAME OF DATE First and completely DECEASED OF DEATH (Type or print) AGE (In years IF UNDER 1 YEAR IF LINDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH 7 MARRIED **NEVER MARRIED** remove last birthday) July 1882 Months Davs Hours WIDOWED DIVORCED 10g JSUAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State or fareign country) INDUSTRY pleose during most of working (Reterited) U.S.A. ottending physician permit. Then please r arm 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Dalton Melvin 17 INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address (Yes, na, or unknown) (If yes give war ar dates af service) 220-50-1838 Holice Dawson. Fallston, Maryland INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per-line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY. ONSET AND DEATH burial-tronset IMMEDIATE CAUSE (o) signed by DUF TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been be detached for use as the State Dept. of Health prior to 19 WAS AUTOPS'
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO DX 20g. ACCIDENT WAS UNDERLYING □ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of Item 18) the hospital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF IN. JRY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) (State) Not While factory, street, office bldg. etc.) of work of work 21. I certify that (I) (this haspital) attended the deceased fram 1 2 - 2 x 19 67 to 12 ---- thot (I) (we) last plnous be retained director, page 3 should should be filed with the 1967, and that death accurred at 4 17 M, fram causes and on the date stated above. saw the deceased alive an 12 22g. SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR M.D 22d ADDRESS 22c PHYSICI**AN** TO HOSPITAL NAME (Type) 23a BURIAL CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) BENOYAL (Sosaly) Darlington. Maryland Franklin Bapt. Cemetery 31 Dec. 67 24. PONERAY DIRECTOR **ADDRESS** 25a. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Home. Aberdeen. Md. 21001 DATE arring Funeral



	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE	### MEDICAL EXAMINER'S CERTIFICATE OF DEATH ### 170	73
HEALTH DEPT.	1 PLACE OF DEATH  O. COUNTY  H 2 - SDT / MARYLAND  2 USUAL RESIDENCE (Where deceosed ved, if institution Residence of STATE M Cd b COUNTY COUN	e before odmission)
Ama 3 Pm3 Pm3 Pm3 Pm3 Pm3 Pm3 Pm3 Pm3 Pm3 P	b. CITY OR TOWN (If outside corporate im ts, write RURAL and give represent town) G 100 C LENGTH OF STAY IN 16 C CITY OR TOWN (If outside corporate im ts write RURAL and give Per 100 C CITY OR TOWN (If outside corporate im ts write RURAL and give	,
THE BOOK	d NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street address)  Haraford Henorial Hospital Box 22	e IS RESIDENCE ON A FARM? YES NO
within 24 haurs after death 1f on pencil in Item 18. Give Pages 1, Examiner's Office along with farm File pages 1 and 2 with the State PE? haurs after death.	3 NAME OF DECEASED (Type or print) Point A Reynold S DEATH Decens be >	
urs afte n 18. G ce alon d2 with	widowed Divorced Aug. 6 1938 29 yrs.	Doys Hours Min
r's iffe	during most of working life, even if retired)  Laborer  Gas Lation  Maruland  Colored  Colore	ZEN OF WHAT
d within 24 in pencil in Examiner's Examiner's File pages 2 haurs afte	13 FATHER'S NAME  Wallace W. Reynolds  15 WAS DECEASED EVER IN U.S. ARMED FORCES?  16. SOC A. SECURITY NO  17 INFORMANT  Address	
be executed v "pending" in nef Medical Ex insit permit. Fil	(1/es, no, or unknown) (If yes give wor or doles of service) 214-36-9804 Howard L. Baker, Elkton, Nd.	
d be d "pe Chief Iransil event	18 CAUSE OF DEATH (Enter on y one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY  (3254 IMMEDIATE CAUSE (o) F - 2 + 4 - 5 - 5 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7	NTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which gave nse to immediate couse (a), stating the underlying couse DUE TO	
This certificate shaul cate, writing the war be farworded to the be used as a burial-remayal, and in any a	PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)	19 WAS AUTOPSY PERFORMED? YES NO 1
	200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH  A CC. A CT. T	10 11 12
AL EXAMINER: sxecute the certificate of the certifi	20c TIME OF NURY Month Doy Year 2Dd IN JRY OCCURRED 2De PLACE OF NURY Home form, 2Dt (City or town) (Cour Hour on Aportory, street office bldg.etc.)	ity) (Stote) -c. 1 Md
AL SAL SAL SAL SAL SAL SAL SAL SAL SAL S	21. I certify that I taak charge of the remains described above, held on Autopsy, Inspection Inquiry, death resulted from: Natural causes, Accident, Suicide, Hamicide, Undetermined manner	and in my ap n on
JTY MEDICA Ty, please ex- eral director be retained if RAL DIRECTO prior to burio	ACTUAL SIGNATURE Devel Poline MD ASS STANT MEDICAL EXAMINER BELLA	22. DATE SIGNED
DEPL cesso e fun may FUNE	EXAMINER'S RAME (Type) G C T 8 / R P / N P DEPUTY MEDICAL EXAM NER (Type) Address (Street, cty, town or county)  230 BURAL CREMATION. 236 DATE THEREOF 230 NAME OF CEMETERY OR CREMATORY 23d OCATION (Cty or Town)	- 20-6 / County) (Stote)
d'a	Philipal 12-23-67 North East Methodist Cem North East Many	land.
VR A15ME 550	Lee H. Patterson & Son, Perryville, Maryland, DATE DEC 28 1967	



301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) . COUNTY Harford Marvland MARYLAND Harford CITY OR TOWN (I outs do corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete I m is, write RURAL end give nearest town) write RURAL and give nearest town)
Bel Air 15 yrs Bel Air . IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d STREET ADDRESS ON A FARMI 607 Maple View Drive 607 Maple View Drive 3. NAME OF 4. DATE Day Midde Month DECEASED OF Defi (Type or print) illiam Lee Robinson DEATH 6. COLOR OR RACE 7. MARRIED | NEVER MARRIED 5. SEX 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR ) IF UNDER 24 HRS. last birthday) Months Male Cau Sept 4,1892 WIDOWED DIVORCED 10e. USUA. OCCUPATION (Give kind of work done during most of working life, even if relied)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY
Harford County
Highway Dept.

11. BIRTHPLACE (State or foreign country)
Rutledge, Maryland I 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Alverta Coe Charles Evans Robinson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT 607 Maple View Drive (Yes, no, or unkown) | (Ifyesgivawarordatasofservice) Mrs. Henrietta Robinson Wife) Bel Air, Md. INTERVAL RETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease **DUE TO** Conditions, if any, which gave risa to immadiata causa DUE TO (a), stetling the underlying cause last. PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART [18] 19, WAS AUTOPSY CERTIFICATION PERFORMED? NO TE should 20b. DESCRIBE HOW INJURY OCCURED, If nor nature of in very in Part II or Part II of item IB 20a, EXTERNAL CAUSE WAS PR,MARY | or CONTRIBUTING | CAUSE OF DEATH. None WEDICAL 20d NJJRY OCCURRED 20e PLACE OF INJURY (Home, farm, 20f. (City or lown) 20c TIME OF INJURY Month, Day, Year (County) factory, street, office bldg., etc.) While Not While at work at work 21. I certify that I took charge of the remains described above, held an Autopsy . Inspection 7 Inquiry X and in my opinion Natural causes 😿 Accident | Suicide Homicide Undetermined manner death resulted from CHIEF MEDICAL EXAMINER ACTUAL DATE SIGNED ASSISTANT MED. CAL EXAMINER should be 1 SIGNATURE Dec 26, 1967 DEPUTY MEDICAL EXAMINER ò Addrass (Straet city, town or county) Bel Air, Md. NAME (Type) aPhilip W. Heuman, M.D. Addr.
228. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCAT ON (City, town, or country) (State) 48 4 5 H REMOVAL (Spacify) Bel Air Mem. Gardens ns Bel Air, Harford 23. FUNERAL DIRECTOR A15ME Kurtz Jarrettsville

s Office along



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 .7085 CERTIFICATE OF DEATH 170 0 2. USUAL RESIDENCE (Where deceased aved, if institution; Residence before admission) PLACE OF DEATH o STATE b. COHNTY county MARYLAND after c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, E CITY OR TOWN (15 outside corporate limits, write RURAL and give nearest town) requires that the death certificate be executed within 24 haurs d STREET ADDRESS e IS RESIDENCE ON A FARM? NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) the attending physician and campletely fitted in YESXX NO DATE 3. NAME OF Month Doy Year OF DEATH DECEASED 19 (Type or print) and in any event, AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED DATE OF BIRTH () last birthdoy Months Dovs Hours Dec. 1887 WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 100 IS JAL OCCUPATION (Give kind of work done during mest of working life, even if ratired) INDUSTRY COUNTRY? Farm 13. FATHER'S NAME MOTHER'S MAIDEN NAMI Address IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service No INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse par-line for (o), (b), ond (c) ONSEL AND DEATH **burial-transit** PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if any, which gave rise to immediate couse (a). DUE TO stating the underlying couse be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been as the lost. WAS AJTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) of Health p use NO 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) of work of work · /3, 19/. / ta / / - / 5 , 19/. / that (1) (we) lost 2). I certify that (I) (this hospital) attended the deceased fram 19 6 / and that death occurred at X227 M, fram couses and an the date stated above saw the deceosed alive on\_ 22b. DATE/SIGNED 22p. SIGNATUR **ATTENDING** MD. PHYS DIRECTOR 22d-ADDRESS PHYSICIANS NAME (Type) directar, 23d LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY (County) (Stote) BURIAL, CREMAT ON 23b DATE THEREOF REMOVAL (Specify) Calvary Methodist Cemetery Maryland 1967 Churchville. Dec. 2Sb. REGISTRAR'S SIGNATURE ADDRESS 2So. REC'D BY REGISTRAR 24. FUNPRAL DIRECTOR 196

3 4

Division of STATISTICAL RESEARCH AND RECORDS, 30	
CERTIFICATE	OF DEATH
: PLACE OF DEATH  o. COUNTY Harford  MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before odmission) o. STATE Maryland b COUNTY Harford
b (ITY OR TOWN (If outside corporate 1 mits, right of STAY IN 1b write RJRAL and give negrest town)	c. CITY OR TOWN (if autside corporate limits, write RURAL and give nearest town) Darlington
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS  e. IS RES DENCE ON A FARM? YES NO
3 NAME OF OCCEASED NATHAN D. SMITH JR. (Type or print)	Last 4. DATE Month Oay Year OF 19 Dec 67 19
Male White WIDOWED DIVORCED	8 DATE OF BIRTH 2 Nov 1905  9 AGE (In years if UNDER 1 YEAR IF UNDER 24 HRS  Only Hours Min
10a USJAL OCCUPATION (G ve kind of work done during most of warking life, even if retired)  Instrument Repairman APG., MdU.S. Go	11 BIRTHPLACE (County & Stote or foreign country)  12. CITIZEN OF WHAT COUNTRY?  U.S.A.
Nathan D.Smith SR. (D)	Rose Belle Handenson (D)
(Yes, no, or unknown) (If yes give wor or dotes of service)	INFORMANT Address  Life Ruth Smith, Darlington, Maryland
18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)  PART I. DEATH WAS CAUSEO BY  IMMEDIATE CAUSE (a)	Corrage throatses INTERVAL BETWEEN ONSET AND GEATH
Conditions, if any, which gave	eroschrois 24/13
nse to immediate couse (a), stating the underlying couse last.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO  200 ACCIDENT WAS UNDERLYING TO 205 DESCRIBE HOW INJURY OCCURRED	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19 WAS AUTOPSY PERFORMED? YES \( \sqrt{N} \) NO \( \sqrt{N} \)
OR CONTRIBUTING CLAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)	(Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA While at work at wo	ACE OF INJURY (Hame, farm, large, street, office bidg., etc.) 20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from L saw the deceased alive an Sect 9 1967, and that	it death occurred at 2P. M, from couses ond on the date stated above
220 AGNATURE De Pli Olis M.	
22c. PHYSICIANS NAME (Type) Du Otey Phillips MD	Directing Tow Md 2034
230 BURIAL, CREMATION, 23b. DATE THEREOF 230 NAME OF CEMETERY OR Smiths Chapel	Cemetery Churchville, Maryland
24 FUNERAY DIRECTOR.  Tarring Funeral Ho Aberdeen, Maryland	250 DEC BY REGISTRAP G 25b REGISTRAR S SIGNATURE



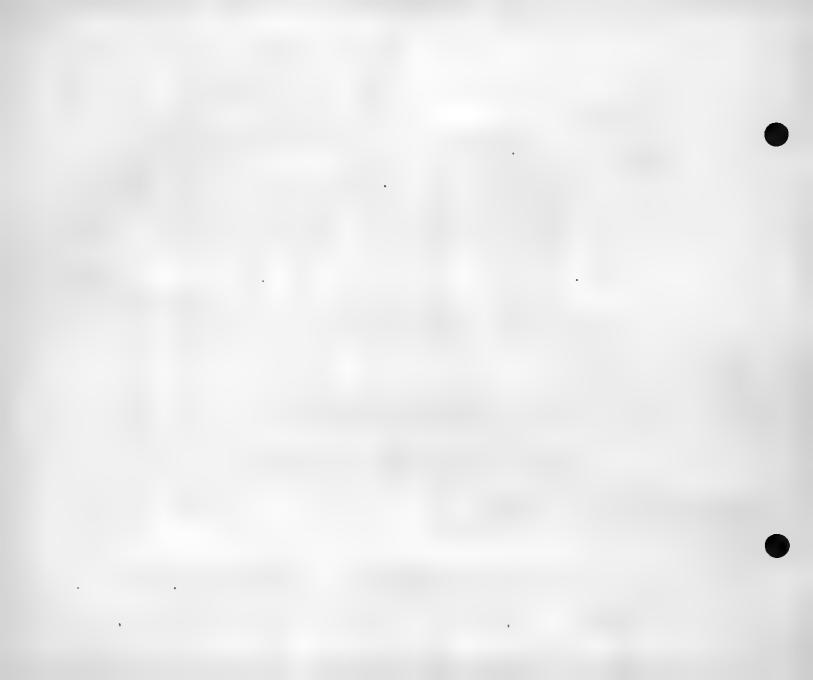
_ 1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	* 7087 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT.	PLACE OF DEATH  O COUNTY Harford  MARYLAND  2 USUAL RESIDENCE (Where deceosed lived, funst tution Res dence before odmission)  O. STATE Maryland  COUNTY Harford
PM3 delay	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Rural - Darlington  c (TY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Rural - Darlington
	d NAME OF HOSPITA. OR INSTITUTION (If not in hospital give street address)  Smith Road (Box #149)  d STREET ADDRESS  B IS RESIDENCE ON A FARM? YES NO X
hin 24 hours offer death 1f of in them 18. Give Pages 1, niner's Off ce olong with form pages I ond 2 with the State Deaus offer death.	3 NAME OF DECEASED (Type or print) William James Sullivan 4 DATE Month Doy Year OF DEATH December 19, 19 67  5 SEX 6 COLOR OR RACE 7 MARR ED NEVER MARRIED 18 DATE OF BIRTH 19 AGE (In years   IF UNDER 14 PER 14 PER 14 PER 15 UNDER 14 PER 15 UNDER 14 PER 15 UNDER 15
urs offi n 18. G ce olor d2 with	Male White WIDOWED DIVORCED July 20, 1918 49 Winthdoy) Wonths Doys Hours Min
24 ho in ther er's Off ges Ton ofter d	1Do USUA, OCCUPATION (Give kind of work done during most of working life, even if retired)  Salesman  11 BIRTHPLACE (Stote or foreign country)  Pittsburgh, Pennsylvania  12 CITIZEN OF WHAT COUNTRY?  LIFE INSURANCE  14 MOTHER'S MAIDEN NAME
d within in pendd Exomine. Fale page	William Sullivan Anna Amelia Flannigan
ecuted in ing" in dica Estamit, Estamit	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Ves. no. or unknown) (If yes give wor oudgotes of service) (If yes give wor oudgotes of service) (Ves. no. or unknown) (If yes give wor oudgotes of service) (If yes give wor oudgotes of service) (Yes. no. or unknown) (If yes give wor oudgotes of service) (Yes. no. or unknown) (If yes give wor oudgotes of service) (Yes. no. or unknown) (If yes give wor oudgotes of service) (Yes. no. or unknown) (If yes give wor oudgotes of service) (Yes. no. or unknown) (If yes give wor oudgotes of service) (Yes. no. or unknown) (If yes give wor oudgotes of service)
MINER: This certificate should be executed within 24 hours offer death 1f of the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, should be forworded to the Chief Medica Examiner's Office olong with farm titles.  3 should be used as a burial-transit permit, File pages land 2 with the State Deation, or removal, and in any event within 72 hours after death.	18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO  Conditions, if ony, which gove nise to immediate couse (o), stating the underlying couse lost.  (c)
This certif tificate, writi Id be forwori uld be used or removol, o	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19 WAS AUTOPSY PERFORMED?  YES \( \sum \) NO XI
ide O ,	PERFORMED?  YES NO  20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of Item 18)  PRIMARY Or CONTRIBUTING No  CAUSE OF DEATH
2 - 4 5 8 6	2Dc TIME OF INJURY Month, Doy, Year Hour o.m. 19 2Dd INJURY OCCURRED White of work of work of work 19 2De PLACE OF INJURY (Home, form, foctory, street, office bldg, etc.)
DEPUTY MEDICAL EXAM sessory, please execute the funeral director. Page 4 may be retained for your FUNERAL DIRECTOR: Page saith prior to burial, crema	21. I certify that I taak charge of the remains described above, held an Autapsy, Inspection 🔀 Inquiry 😿, and in my apin'an death resulted fram: Natura causes 🔂 Accident, Suicide, Hamicide, Undetermined manner
JIY MEDIC, ry, pleose e eral director be retained RAL DIRECT prior to buri	ACTUAL SIGNATURE Philipped Oderward MD ASSISTANT MED CAL EXAM NER DEPUTY MED C
TO DEPUTY MEDICAL EXA necessory, please execute the funeral director. Page 5 may be retained for you TO FUNERAL DIRECTOR: Page Health prior to burial, cren	EXAMINER'S Philip W. Houman, M.D. DEPUTY MED CAL EXAM NER Dec. 19, 1967  NAME (Type) 307 Hickory Ave. Bol Air. Md. 21014 Address (Street, city, town or county)  230 BURIAL (CREMATION, 23b DATE IHEREOF 23c NAME OF CEMETERY OR (REMATORY 23d LOCATION (City or Town) (County) (Stote)
5 = = 5 = 0	Buriai Dec. 21, 1967 St. Ignatius Church Cem. Hickory, Harford Co., Md.
VR A15ME (\$) 11	Joseph William Bel Air, Maryland 21014 DATEC 26 1967 privates Jungs

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1 .	It 1	ems 18,19&21 Film 396 MARYLAND STATE DEPARTMENT OF HEALTH 2-18-67 ams division of vital records, 301 W. Preston Street, Baltimore, Maryland 21201
FOR STATE	-	MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEELI		PLACE OF DEATH  O COUNTY  MARYLAND  2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)  O STATE  M   MARYLAND
y de gram artm	ŀ	to (ITY OR TOWN (If outside corporate imits, write RURAL and give nearest town)  write RURAL and give nearest town)  to the composition of the com
form form	3	d NAME OF MOSPITAL OR NSTITUTION (If not in hospital), give street oddress)  d STREET ADDRESS  B on 7-bur Street oddress)  Residence On A FARM?  YES   NOC
Pog with		NAME OF DECEASED (Type or print) Oh wirst F Suton J, BATE DECEMBEY 19
rs ofter 18. Give e olong 2 with th oth.	S	SEX 6 COLOR OR RACE 7 MARR ED NEVER MARRIED B DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS ost birthdoy) WIDOWED DIVORCED MAR. 23, 1909 58 birthdoy) yes
24 hours in Item 1 r's Off ce es land2 ofter deoth	dur	-USUAL OCCUPATION (Give kind of work done ing most of working life, even if refired)  PAIN   ER
d within in pencl Exominel File page 2 hours o	13	FATHER'S NAME TO HN F. SUTOR, SR. EDITH M. SUTOR
executed with modical in permunity in permunity file within 72 hours.		WAS DECEASED EVER IN U. S. ARMED FORCES?  16 SOCIAL SECURITY NO 17 INFORMANT  Address 6401 Haglewill AV, 15, no, or unknown) (If yes give wor or dates of service) 213-16-4664 MRS. EMMA 7 ALVEY BALTE-MD-21206
houd be word "pe the Chief rriol-tronsi		The Cause of Death (Enter only one couse per line for (o), (b), ond (c).)  PART I DEATH WAS CAUSED BY  IMMEDIATE CAUSE (c)  Conditions, fony, which gove is to immediate couse (o).  Storing the underlying couse lost  (c)  INTERVAL BETWEEN ONSET AND DEATH
	ATBON	PART II OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0)  19 WAS AUTOPSY PERFORMED? YES NO IX
無力 聖皇	L CERTIFICATION	200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CONTRIBUTING CAUSE OF DEATH  CAUSE OF DEATH  20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port or Port II of item 1B)
	MEDICAL	20c TIME OF INJURY Month, Day, Year  Hour o.m.  19  20d INJURY OCCJRRED  20e PLACE OF INJURY (Home form foctory, street, office bldg., etc.)  foctory, street, office bldg., etc.)
iei, general de la company de		21   certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from. Natural causes , Accident , Suicide , Hamicide , Undetermined manner
Me) K. Me) K. Me)		ACTUAL SIGNATURE Level & Falme MD ASSISTANT MEDICAL EXAM.NER BE/ A: 1- 1- 122. DATE SIGNED
O DEPUTY I necessary, p the funeral is 5 may be read to FUNERAL I Health prior		EXAMINER'S NAME (Type) Gerold & Palmor up DEPUTY MEDICAL EXAMINER (A Address (Street, city, town, or county) 12-4-47
To E	_	BURIAL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City or Town) (County) (Store)  BERMOVAL (Specify) 12-7-1967 ANCHEL HILL CEM. Havrede Grave, Harford Wild,
VR A 15ME (6)	4	Madison Mitchell Haved Gray W. DEC 8 1967 Clearles Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death, PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death funeral l and and 2. USUAL RESIDENCE (Where deceased tived, if institution. Residence before admission PLACE OF DEATH n. COUNTY b. COUNTY Harford MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) yrs Aberdeen ABERDEEN IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS papers hin 72 h filled 670 West Bel Air Ave KIRK ARMY HOSPITAL, ABERDEEN PG. MARYLAND NO X 3 NAME OF First 4. DATE Month <u>=</u> Year campletely DECEASED 19 67 (Type or print) HUGH COURTNEY SUTTLE DEATH COT AGE (in years F UNDER 1 YEAR F UNDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH 7 MARRIED **NEVER MARRIED** lost birthday) Months Hours 23 NOV 1910 and in any Male Cau WIDOWED DIVORCED 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) COUNTRY? during most of working life, even if retired) INDUSTRY US\_A Perry Co, Perryville, Ala USA Soldier 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal, JAMES B. SUTTLES DELLA BYRD Address Aberdeen, Md. 17 INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, ar unknown) (If yes give war ar dates of service) Dorothy Suttle, 670 West Bel Air Ave 420-20-5825 May 1942 signed by the atter burial-transit perm burial, crematian, a INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c), PART I DEATH WAS CAUSED BY INSCAND DEATH Gunshot Wound of Neck IMMEDIATE CAUSE (n) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse After this certificate has been be detached for use as the State Dept. of Health prior ta 19. WAS AUTOPSY PERFORMED? PART -1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) YES XX NO 200 ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 1 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Removing weapon from automobile 20e PLACE OF INJURY (Home, form, 20f (Cty or town) 20c TIME OF INJURY Month, Day, Year 20d WIJRY OCCURRED (Stote) factory, street, office bldg, etc.) 1130 xxx Dec 27 19 67 Harford Marylan Aberdeen at work of work Home 10 FUNERAL DIRECTOR: After 21. I certify that (1) (thicknessed of a tended the deceased from 27 Dec 67, 1967, to 27 Dec . 19.67, that (1) (seek last 19 and that death accurred at 1130AM, from causes and an the date stated above saw the deceased alive an 27 Dec 67 220 SIGNATURE 22b DATE SIGNED Williams 27 Dec 67 DIRECTOR M.D. PHYS. directar, page 3 should be filed v 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) KIRK ARMY HOSPITAL.ABERDEEN PG.MARYLAND WILLIAM W. BABSON. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230. BURIAL, CREMATION. (County) (State) REMOVAL (Specify) Halinoton National REC D BY REGISTRAR 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR ADDRESS VR A15 (4) 25M 1/67 DATE JAN

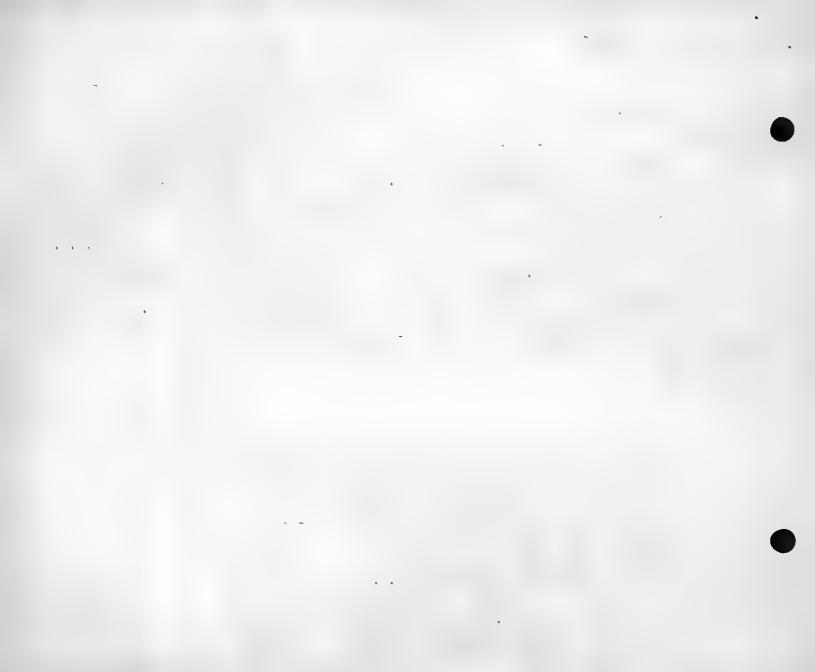


NAME OF FIRST    NAME OF FIRST   Models   NAME   NAME   Dev	MARYLAND STATE D  DIVISION OF STATISTICAL RESEARCH AND RECORD	EPARTMENT OF HEALTH 5, 301 W. PRESTON STREET, B	BALTIMORE 1, MARYLAND
PARCE OF DEATH   County   Co	Ttem #9 Fi CERTIFICAT	E OF DEATH	1.085
d. MARE OF HOSPITAL OR DISSTITUTION (of not in bospilar), also street address)  3. NAME OF DECEMBER  (in por print)  (in port print)	Harferd Marshand	Mausland	b. county
NAME OF THE PROPERTY   Day   MARGINATUR   Day   Marginature   Da	write AURAL and give nearest toler of mo.	Hande &	eace
DECRREP  OF ATTOR  DEATH  (Type or prior)  (So COLOR OR RACE)  (AMARRIED   NEVER MARRIED   B. DATE OF BIRTH  (D. AGAINA AREN   IF UND  (D. AGAINA AREN  (D. AGAINA  (D. AGA	Brewin Musing Home	Bein Mins	cis Home YES
NOTO SUSUAL OF CLEAT ION (GIVE kind of work one suggested	(Type or print) MARGEURITE	TAYLOR OF DEATH	12/8/67 19
ADDRESS OF DEATH (Inter only one cause paying to (c).   Dy and (c).	temale While WIDOWED DIVORCED [	6/22/1904 001	Asi birthdey) Months Days Hours
15. WAS BECEASED EVER IN U.S. ARMED FORCEST   16. SOCIAL SECURITY NO. 17. INFORMANT   Address   Laffly Card	done during shost of working like, even if selfied)	STRY II BURTHPLACE (County & Stelle or to	Lance U.S. A
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b); and (c), (c)  (c), (c), (c), (c), (c), (c),	William Steetle	Elizaki U	linton
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which gave rise to immediate cause (b)  DUE TO  Conditions, if any, which gave rise to immediate cause (b)  PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS PER OR ACCIDENT WAS UNDERFUNDED.  DO ACCIDENT WAS UNDERFUNDED.  OR CONTRIBUTING CAUSE OF DEATH (IF ETHER, NOTIFY MEDICAL EXAMINER)  20c. ACCIDENT WAS UNDERFUNDED.  20c. TIME OF INJURY Month, Dey, Year How a.m. 19 all work   21. I certify that (I) (this hospital) altended the deceased from 19 in io	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 19 (Yes, no, or unkgwa) (If yesgive war or dates of service)	Backery W. Tanon	2/34 Kaffey Coul
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lest.  PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS DEC.  PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS DEC.  PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS DEC.  PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS DEC.  PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS DEC.  PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS DEC.  PER THE OFTEN OF DESCRIPTION (County) In Part I of Item 18.]  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20c. PLACE OF INJURY (Home, ferm, 20t. (City or town) (County) Industry (Home, ferm, 20t. (City o	PART I, DEATH WAS CAUSED BY	e le blions Entone	disease INTERVAL BI
DUE TO    Sausse last   Due to	TT-1 DUE TO astern	soscletons.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS PER OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20a. ACCIDENT WAS UNDERLYING OR CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. 20t. (City or town) (County)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED at work all work all work all work all work all work.  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. 20t. (City or town) (County)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. 20t. (City or town) (County)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. 20t. (City or town) (County)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. 20t. (City or town) (County)  20c. TIME OF INJURY MONTH, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. 20t. (City or town) (County)  20c. TIME OF INJURY MONTH, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. 20t. (City or town) (County)  20c. TIME OF INJURY MONTH, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. 20t. (City or town) (County)  20c. TIME OF INJURY MONTH, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. 20t. (City or town) (County)  20c. TIME OF INJURY MONTH, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. 20t. (City or town) (County)  20c. TIME OF INJURY MONTH, DAY, Year 20d. (City or town) (County)  20c. TIME OF INJURY MONTH, DAY, Year 20d. (City or town) (County)  20c. TIME OF INJURY (Home, ferm. 20t. (City or town) (County)  20c. TIME OF INJURY (Home, ferm. 20d. (City or town) (County)  20c. TIME OF INJURY (HOME) (Home, ferm. 20d. (City or town) (Cit	gave rise to immediate cause (a), stating the underlying  DUE TO		
20c. CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH How a.m. p.m. 19 20c. TIME OF INJURY Month, Day, Year How a.m. p.m. 19 21. I certify that (I) (this hospital) attended the deceased from 21. I certify that (I) (this hospital) attended the deceased from 21. I certify that (I) (this hospital) attended the deceased from 22a. SIGNATURE  22a. SIGNATURE  23a. BURIAU CREMATION, 23b. DATE THEREOF REMOVAL (Specify)  24. UNERAL DIRECTOR'S SIGNATURE  25b. REGISTRAR'S SIGNATURE  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of .n.,ury in Part II of item 18.)  (County) (Cou	(6)		ONDITION GIVEN IN PART I(a) 19. WAS PERF
20c. TIME OF INJURY Hour a.m. p.m. 19   And while at work   20d. INJURY OCCURRED while at work   20d. INJURY (Home, farm, farm, farm, factory, street, office bldg., etc.]  21. I certify that (I) (this hospital) attended the deceased from	200 ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCU	<i>p</i> · .	
21. I certify that (I) (this hospital) attended the deceased from		PLACE OF INJURY (Home, ferm,   20t. (City	or lown) (County)
saw the deceased alive on			
ATTENDING MED. STAFF PHYS. DIRECTOR DIRECTOR OF CEMETERY OR CREMATORY COUNTY)  23a BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY CLEFTON OF COUNTY)  REMOVAL (Specify) 12/1/1/7 MT. Comfort 25a. REC'D 8Y REGISTRAR 25b. REGISTRAR'S SIGNATURE			
22c. PHYSICIAN'S NAME (Type)  LAJOS I. MEZEI. M. D.  23d. BURIAD CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF CREMATORY  REMOVAL (Specify)  12/11/67  M. D.  24 FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  22d. ADDRESS	22a. SIGNATURE	L DUNCE TO DIRECTOR	
23a BURIAD CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, Iown or county)  REMOVAL (Specify) 12/11/17 Mg. Comford Clefendra (a.  24 FUNERAL DIRECTOR'S SIGNATURE) ADDRESS 25a. REC'D 8Y REGISTRAR 25b. REGISTRAR'S SIGNATURE	NAME (Type)	22d. ADDRESS	
	238 BURIAD CREMATION, 235. DATE THEREOF 23c. NAME OF CEMETE	RY OF CREMATORY 234, LOCA	TION (City, town or county)
	34 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTR	RAR 256. REGISTRAR'S SIGNATURE  1967 Villanda VIII



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
	7691 CERTIFICATE OF DEATH
1	PLACE OF DEATH  o. COUNTY HARFORD  MARYLAND  2. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before odmission)  o. STATE MARYLAND  HARFORD
_	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  ABERDEEN PROVING GROUND  d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  c LENGTH OF STAY IN 1b  c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  ABERDEEN PROVING GROUND  d STREET ADDRESS  e 15 RESIDENCE
	KTRK ARMY HOSPITAL, ABERDEEN PG. MD. 2756 C AUGUSTA STREET YES NO
L	DECEASED (Type or point)  TRACEY  LAMOENT  TAYLOR  OF DEATH  DEC  18 19 67  SEX  6 COLOR OR RACE  7 MARRIED  NEVER MARRIED  NEVER MARRIED  DEC  18 19 67
	MALE NEG WIDOWED DIVORCED 18 DEC 67 PYTS MORTHS DOYS HOURS MAILE OU USUAL OCCUPATION (Give kind of work done uning most of working life, even if retired)  10 KIND OF BUSINESS OR II BIRTHPLACE (County & State, or foreign country)  11 BIRTHPLACE (County & State, or foreign country)  12 CITIZEN OF WHAT COUNTRY?
1	INFANT N/A HARFORD CO, MARYIAND USA 3. FATHER'S NAME 14 MOTHER'S MAIDEN NAME  FATRLY W. TAYLOR BRENDA JAGOE
1 (	S WAS DECEASED EVER IN U. S ARMED FORCES? Yes, no, or unknown) (If yes give wor or dotes of service) NO  N/A  BRENDA TAYLOR, 2756 C AUGUSTA ST, APG, M.
	IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART I. DEATH WAS CAUSED BY ONSET AND DEATH  ONSET AND DEATH  ONSET AND DEATH  Conditions, if any, which gave rise to immediate cause (o), storing the underlying cause lost  (c)
FICATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)  19 WAS AUTOPSY PERFORMED? YES X NO  200 ACCIDENT WAS UNDERLYING 1 200 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port II or Port II of item 1B.)
ASDICAL CEPTIFICATION	OR CONTRIBUTING CLAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c TIME OF NUJRY Month, Doy, Year Hour o m.  19 Not While of work  19 Not While of
	21. I certify that (I) (this-hespital) attended the deceased from 18 DEC , 1967, to 18 DEC , 1967 that (I) (mo) saw the deceased alive an 18 DEC 1967, and that death occurred at 045 AM, from causes and on the date stated about 220 SIGNATURE.
	The physician's Acids Color Mc MD Phys Director Director Director 18 DEC 67
	30 BURIA. (REMATION, 236 DATE THEREOF 236 NAME OF CEMETERY OR CREMATORY, 23d LOCATION (City of Jown) (County) (Store)  REMOVAL (Specify) 12-21-67 Ruleigh Material Cemetery Ralligh North Curolin
2	24. FUNERAL DIRECTOR  Sullack's Mortinary 556 Louis So. Thoras & Grace, M. DATE DEC 27 1987

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 709? MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission. o COUNTY b. COUNTY o. STATE Page 2 HARFORD MARYLAND Maryland HARFORD 4 delay c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) b City OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 15 Aberdeen Proving Ground Havre de Grace e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d. STREET ADDRESS 4 Star Trailer Camp KIRK ARMY HOSPITAL NO A and 2 with the State YES | be executed within 24 haurs after death NAME OF Middle 4 DATE F rs1 lost Month Dov Year DECEASED VANCE SHERRY N. DEATH December 1967 Type or print ward "pending" in penct in Item 18 Give the Chief Medical Examiner's Office atong F UNDER 24 HRS B DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Doys 15 Months Hours 21 July 1967 72 hours after death. White WIDOWED DIVORCED Female 4 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT U.S.A. during most of working life even if retired) Infant APG. Maryland 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME Kenneth P. Vance Drucilla S. Martin IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, ng. munknown) (If yes give war ar dates af service event within N/A Father. Same as 2 C & D. NTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (a) (b) and (c).) ONSET AND DEATH bur al-fransit PART 1 DEATH WAS CAUSED BY Acute otitis media (SDII) MMEDIATE CAUSE (o) This certificate shauld DUE TO any Conditions, if any, which gave te, writing the v farwarded ta ti (b) rise to Immediate couse (a), DUE TO stating the underlying couse lost. 19 WAS AUTOPSY PERFORMED? ar remaval, PART 1 OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PART 1(o) CERTIF CATION YES X NO 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of Item 18) PRIMARY OF CONTRIBUTING Page 4 shauld CAUSE OF DEATH. 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, form 20f (City or town) (County) (State) Hour om. foctory, street, office bldg , etc.) Not While of work may be retained for your FUNERAL DIRECTOR: Page of work 21 1 certify that I took charge of the remains described above, held an Autapsy X Inspect on [ Inquiry [ and in my apinian funeral director. death resulted from: Natural causes 💢 Suicide Accident Homic de Undefermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIGNATURE DEPUTY MEDICAL EXAMINER December 7, 1967 **EXAMINER'S** Charles S. Springate, M.D. llea th NAME (Type) Address (Street city town, or county) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL CREMATION 23b DATE THEREOF (County) (Stote) 50 REMAY Sparty) 11 Dec. 67 Baltimore National Cemetery, Baltimore, Maryland 25b REGISTRAR'S SIGNATURE Tarring Functors Home 250 REC D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15ME (5 Whanker Aberdeen, Maryland 1967 6M 1/67



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 7693 CERTIFICATE OF DEATH death. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH **b** COUNTY p. COUNTY o. STATE MARYLAND c. LENGTH OF STAY JN 16 CITY OR TOWN (If quits de carografe semits. c CITY OR TOWN (If gutside corparate limits, write RURAL and give negrest town) write RURAL and give megrest town) requires that the death certificate be executed within 24 haurs e IS RESIDENCE ON A FARM? NAME OF HOSPITAL OR INSTANTITION (If not in hospital, give street address) d STREET ADDRESS popers. NO Y YES emoria NAME OF DECEASED DATE Month First 3 19 DEATH 0 AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE lost birthday) Months Hours 30 June 1901 WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o USUAL OCCUPATION (Give kind of work done JOB KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) Bata Shoe Company COUNTRY during most of working life, even if retired) Russell Virginia Machine Operator 13 FATHER'S NAME 14 MOTHER'S MATDEN NAME 0 m 17 INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service Havre de Grace, Maryland Frank S. Webb. Νo INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) burial-transit DNSET AND/DEATE PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause IO FUNERAL DIRECTOR: After this certificate has been #e last. WAS AUTOPSY PERFORMED? PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 160) NO for 205. DESCRIBE HOW INJURY OCCURRED. (Enter/noture of injury in Part I or Part II of item 18.) 200 ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (State) 204 INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c TIME OF INJURY Manth, Day, Year factory, street, affice bldg-etc.) Hour a.m. Not White ot work TO HOSPITAL OR ATTENDIN Page 4 may be retained by 21. I certify that (1) (this hospital) aftended the deceased from 11 - 28 - 62, 19 , to 12 and that death accurred at 2100 M, from causes and on the date stated/above. 1965 saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D. DIRECTOR PHYS ADD RESS -22- PHYSICIAN'S 22d. NAME (Type) director, should 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 23b. DATE THEREOF 23o. BURIAL, CREMATION, REMOVAL (Specify) (Rarford) Maryland Bel Air Memorial Gardens Bel Air 14 Dec. 1967 250 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR Tarring Puneral Home VR A15 (4) 210011FC 20 M 1/66 Aberdeen, Md.



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 7094 . /039 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 24 hours after death. deoth and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) the funero o. COUNTY **b.** COUNTY Harford buriol, cremotion, or removal, and in any event, within 72 hours after MARYLAND Maryland b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c LENGTH OF STAY IN 16 c CITY OR TOWN (If guiside carparate limits, write RURAL and give nearest tawn) Rising Sun Havre-de-Grace davs Rural d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e IS RES DENCE ON A FARM? d STREET ADDRESS Harford Memorial R. F. D. Hosp. YES NO DO 3 NAME OF First Middle Year completel please remove carbo DECEASED OF DEATH 12----26----- 67 Ma l.va Bird Weir (Type or print) SEX 6 COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED 120 **NEVER MARRIED** lost birthday Months Dovs Hours Female White WIDOWED DIVORCED 9--12--1898 puo 10a USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)
House Wife Own Home ottending physician permit. Then please Cecil Co. Md. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Wilmer Curtis Bird Bella Snyder 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address permit. (Yes, no, or unknown) (If yes give wor or dotes of service Mr. Harry Weir Sr Rising Sun. No None signed by the c burial-transit p IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o' Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if any, which gove erioscleros 0 rise to immediate couse (a), DUE TO stoting the underlying cause be detoched for use as the State Dept, of Heolth prior to lost WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO X certificate 20o ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port | or Port |) of item |B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) Hour om factory, street, office bldg, etc.) Not While at work L at work TO FUNERAL DIRECTOR: After 1967, to 12-26 21. I certify that (I) (this haspital) attended the deceased from 12-5 1967, that (I) (we) last director, page 3 should should be filed with the saw the deceased alive an 12-26 19 67, and that death accurred at 7:30M, from causes and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED STAFF PHYS ATTENDING M.D DIRECTOR PHYS 22d ADDRESS 22c PHYSICIAN'S NAME (Type) Rising Sun. **BURIAL, CREMATION** DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Oxford Cem. rria Oxford ADDRESS 250 REC'D BY REGISTRAR REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Rising Sun. Mcd DATE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 17095 death. requires that the death certificate be executed within 24 hours after death Uneral Tand PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY Harford a COLINTY a. STATE Harford Maryland MARYLAND b. CITY OR TOWN (If autside corporate limits, c LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give nearest town) White White Hall RD #1 Box 55 vrs. d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? completely filled YES NO X Norrisville Road Norrisville Road NAME OF Middle DATE Lost Month Doy Year DECEASED Vec. 19 6 (Type or print) DEATH S. SEX 9. AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE DATE OF BIRTH IF UNDER 24 HRS. NEVER MARRIED remove birthday) Months Days Hours Female White WIDOWED X DIVORCED 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) INDUSTRY COUNTRY? Housewife Home Harford Creamery.Md. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAMI ar removal, Luella Andrew L. Anderson Jackson 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 1 Box 55 Frances (Yes, na, or unknown) (If yes give war ar dates of service) No Luckey 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) 21161 INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any, which gove rise to immediate cause (a). DUE TO stating the underlying couse the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been the last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? NO F YES [ for 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item IB.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth. Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form. (City or lown) (County) (Stote) factory, street, office bldg., etc.) Not While at wark at wark O HOSPITAL OR ATTENDIN Page 4 may be retained by å do 12/26 21. I certify that (I) (this hospital) attended the deceased fram. 1967, that (I) (we) tost saw the deceased alive an , and that death accurred at 2 M, fram causes and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR PHYS , page 3 be filed PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, (County) (State) Burial (Specify) 12/28/1967 Bethel Madonna. Harford. 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR VR A15 (4) 1967 Jarrettsville, Md. Charles E. Kurtz 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17096 CERTIFICATE OF DEATH 17091 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY a. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give nearest rawn requires that the death certificate be executed within 24 hours vithin 72 hours e. IS RESIDENCE ON A FARM? NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) Schuster Road YES T NO K 4. DATE NAME OF Manth carban DECEASED OF DEATH (Type or print) IF UNDER I YEAR S. SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED birthday) Months Days Haurs WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired) INDUSTRY Floyd, Virginia Assessor 13 FATHER'S NAME William E. Wimmer Cora Elizabeth Walton 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, go, ar unknown) (If yes give war or dates of service) 3-01-9901Steven P. Wimmer Jarrettsville.Md. 210841 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c). burial-transit ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO IX YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY-MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street office bldg., etc.) Not While al work at work L . 1967 to 12 - 16 \_, 19<u>6</u> 7, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased from 12/1.3 130 M, fram causes and an the date stated above. 1967, and that death accurred at saw the deceased alive an... 22b. DATE SIGNEE 220. SIGNATURE M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) directar, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City of Town) (County) (State) 230. BURIAL, CREMATION 12/19/1967 Bethel Madonna. Harford. 25b. REGISTRAR'S SIGNATURE ADDRESS 2Sq. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Villaneas Judan DATE DEC 20 196/ Jarrettsville. Charles E. Kurtz Md. 20 M 1/66

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